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ABSTRACT

Urban maternal and child health (MCH) leaders from city and county health departments nationwide came together at this conference for professional development and networking. Selected plenary presentations included in these "highlights" are: (1) "Urban Children in Need: Responsible and Responsive Leadership" (Margaret A. Hamburg); (2) "National, Federal, State, and Local Approaches to Implementing the Childhood Immunization Initiative" (Donald Williamson); (3) "Violence and Public Health: Problems to Policies" (Ellen Anderson); and (4) "Local Public Health Leadership in Times of Transition" (Meredith Tipton). Selected topical workshop presentations included are: (1) "School-Based Clinics and Local Health Departments: The Denver Experience" (Paul Melinkovich); (2) "TB Reemerges in Urban Communities: Implications for MCH" (three case studies) (Hugh F. Stallworth, Grace Rutherford, and Gary Butts); and (3) "Women's Health 1994: Three Health Issues of Concern to Women. Women's Health: Colposcopy Services" (Margaret Gier). Each urban health department attending the conference was required to contribute a detailed profile of one promising MCH urban initiative. These 84 profiles, assembled and indexed, form the bulk of this report. Three appendixes discuss conference planning, program, and participants. (SLD)

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Effective Leadership During Times of Transition

1994 Urban MCH Leadership Conference

September 18-21, 1994

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Conference Highlights

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Effective Leadership During Times of Transition

Highlights of the 1994 Urban Maternal and Child Health Leadership Conference

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CityMatCH is a national organization of urban maternal and child health programs and leaders. **CityMatCH** was initiated in 1988 to address the need for increased communication and collaboration among urban and maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. **CityMatCH**, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. **CityMatCH** also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States. For more information about **CityMatCH**, contact Magda Peck, **CityMatCH** Executive Director, Department of Pediatrics, University of Nebraska Medical Center, P.O. Box 982170, 600 South 42nd Street, Omaha, NE 68198-2170, Telephone (402) 559-8323.

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Some say the Fifth Urban Maternal and Child Health Leadership Conference held in the Fall of 1994 in Washington, D.C. was the best one yet. Of this I am certain. Urban maternal and child health leaders from city and county health departments nationwide came together for professional development and networking. While they commented widely on the thrill and productivity of being together, the hard work that went into putting the conference on did not go unnoticed. A magnificent team of conference organizers, coordinators, and administrators did a stellar job once again.

CityMatCH is fortunate to sustain a small, excellent staff in the Section on Child Health Policy, Department of Pediatrics at the University of Nebraska Medical Center (UNMC) in Omaha, Nebraska. **CityMatCH** Administrative Technician, Joan Rostermundt, handled logistics with grace and efficiency. Conference Coordinator, Harry Bullerdiek, applied his managerial talents in such a way that things just had to go smoothly. Coordinator of Special Projects at **CityMatCH**, Elice Hubbert, lent her expertise to the Profiles, Small Workgroups, and SpotLights. Additional staff assistance came from Diana Fisaga and Chris Kerby. And the **CityMatCH** staff had lots of help. Conference materials were designed by Helen Gloeb and Joe Edwards at the UNMC's Department of Biomedical Communications. Printing came through under the direction of Mark Watson at UNMC's Printing and Duplicating Services. The National Center for Education in Maternal and Child Health's wonderful conference organizing team - Paula Sheahan, Susana Eloy, Kate Ryder, Sue Hutchings, and Jennifer Kehoe - handled on-site logistics without a flaw.

Conference Co-Chairperson Len Foster, Deputy Director of Public Health for the Orange County Health Care Agency in Santa Ana, CA, did a marvelous job of leading the **CityMatCH** family. A hard working and creative Conference Planning Committee shaped the program, helped secure effective speakers and guided us through the planning process. Patricia Tompkins, the Maternal and Child Health Chief of the District of Columbia Department of Human Services, and her terrific staff again arranged an excellent tour of D.C. Area programs. As always, we are indebted to our many funders and co-sponsors whose support is undeniably essential.

CityMatCH's mission is to enhance the ability of maternal and child health programs at the local level to improve the health and well-being of children and families in urban areas. This conference goes a long way in allowing this mission to be fulfilled because it fosters the active participation of the MCH directors, who take the time to renew their commitment to urban MCH and their colleagues nationwide. I acknowledge, with great appreciation and gratitude, the hard work of every individual who makes the special connections within the **CityMatCH** family happen.

Magda G. Peck, Sc.D.
CityMatCH Executive Director & CEO
Co-Chairperson, 1994 Urban MCH Leadership Conference

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U.S. Conference of Local Health Officers
U.S. Conference of Mayors

Welcoming Remarks
Fifth Annual CityMatCH Conference

Sunday
September 18, 1994

Len Foster, MPA
Co-Chair, 1994 Urban MCH Leadership Conference
Deputy Director of Public Health
Orange County, CA

It is my pleasure to welcome you to this fifth annual Urban MCH Leadership Conference.

I am pleased to see both so many familiar faces from previous meetings, and so many new MCH leaders to this tremendous learning environment.

As local MCH leaders we spend much of our time dealing with the details of program operations and management issues. Personnel, space, financing, and the ever increasing demands on our infrastructure. These are awesome responsibilities and ones which require constant tending.

Added to this are the realities of managed care, national health care reform, low immunization levels, violence, HIV, the resurgence of tuberculosis, and many other issues. The challenge seems, at times overwhelming - **No one** can succeed.

That is precisely the point of the CityMatCH organization. When it was created six years ago, it was in recognition of the reality of our times. As local MCH leaders we share many common experiences, face many of the same challenges, and have learned many of the same painful lessons. No one of us has all the solutions. CityMatCH was visualized as an organization which could assist local MCH leaders to learn from each other - to share the wealth of knowledge and experience which is represented by our members.

The theme of this year's conference is **"Effective Leadership During Times of Transition."** It is my view that this theme reflects two basic transitions which directly effect all local MCH leaders.

The first transition is the one represented by managed care and national health care reform. There is a palpable level of anxiety among many local MCH leaders about what this transition means for them and their traditional responsibilities and funding base. How can local health departments compete with the private sector? Who is going to pay for the unique care provided by public health programs? What will happen to my clinics?

The other transition I view as philosophical. The Hebrew word "Tshuva" literally means to return. When applied to present day public health "Tshuva" can mean returning to our roots. To take a step back from the overwhelming one-on-one patient care responsibilities which face each of us every day, and begin again to view the community in its entirety as our patient. In my opinion, this is the more important transition.

Effective leadership is essential for us to be successful in making these transitions. Leadership assumes many forms, and it varies from community to community and situation to situation. All of us exert leadership. The test of effective leadership is how well it works. During the next three days you will have the opportunity to explore a variety of leadership styles and examine examples of leadership which was successful, and perhaps a few which were not. It will be up to each of us to sift through the information presented and to discover those elements which have the most meaning to us as individual MCH leaders within the context of our own community.

CityMatCH and this conference are about sharing. Do not forego the opportunities to interact with your colleagues from across the country. There will be opportunities for you to meet your colleagues from communities of similar size. There will be opportunities for attendees from the same federal region to meet together as well. Use these times and others to establish contact with your peers and to build networks from which to draw continued support when you return home.

I would like to take this opportunity to express, on behalf of CityMatCH, and the Conference Planning Committee, my appreciation for the support which we have received from the numerous co-sponsors, including the Maternal and Child Health Bureau, Centers for Disease Control and Prevention, March of Dimes, National Center for Education in Maternal and Child Health, Association of Maternal and Child Health Programs, National Association of County and City Health Officials, and many others.

Opening Remarks

Sunday
September 18, 1994

Ciro V. Sumaya, MD., M.P.H.T.M.
Administrator,
Health Resources and Services Administration
U.S. Public Health Service

I'd like to add my welcome to this fifth annual urban MCH Leadership Conference sponsored by CityMatCH. It is, indeed a pleasure for me to be with you this afternoon, and it's good to see so many [new, familiar] faces.

I'd like to take this opportunity to express my thanks to all of you who were involved in coordinating this conference. You've done an excellent job. HRSA's Maternal and Child Health Bureau is proud to sponsor this year's conference with the Centers for Disease Control. Additional funding comes from the National March of Dimes Birth Defects Foundation and the University of Nebraska.

This group has grown significantly since 1990. Nearly 50 of you came together at that first conference to build the urban MCH network--and to begin sharing information about dealing with the health needs of children and their families in cities across the country. Over the last four years, representatives from about a growing number of cities have met to continue the dialogue about what works, what doesn't, and why. Now, the partnership is in place, and communication and collaboration efforts are clearly underway. It seems appropriate to shift the focus now to leadership.

This year's theme, "Effective Leadership During Times of Transition," will begin to address concerns that face us all in a time of potentially dramatic change and in a climate of increasing need and decreasing resources. Many questions loom large:

- Are there enough strong, skilled leaders who can design, implement and evaluate effective interventions?
- Is there access to timely and reliable data to monitor your efforts and plan for the future?
- Where will the new money come from?
- How can we create collaborative efforts with State and Federal MCH colleagues instead of arguing over limited resources?

These and many other questions are being addressed at this conference, and I wish you continued success in grappling with these issues.

And as you deal with these challenges, I want you to be assured that the President Clinton, the Secretary Shalala, the PHS, HRSA, and the Maternal and Child Health Bureau are committed to the health and well-being of urban children and their families. We demonstrate this commitment in support for a variety of initiatives that target or involve American cities--Dr. Nora has alluded to many of these.

Clearly, the "Healthy Start" initiative is stimulating local and state collaboration to deal with the complex problem of infant mortality. These kinds of collaborations will assure the longevity of Healthy Start long after the initial five-year period. Those cities that are funded need continued encouragement, support and guidance. To those cities that have not been funded--I encourage you to continue the process of needs assessment and interagency planning and collaboration.

This conference is one place to do that, to find out, for example, about alternate sources of funding to sustain these activities in communities that haven't been funded yet. The Federal government must work with communities that receive Healthy Start funds to integrate Healthy Start efforts with other MCH-related activities in local health departments and community health centers. And we must reassure local communities that investments in Healthy Start and other special initiatives are not taking critical resources away from existing MCH programs.

Urban MCH programs are the front line partners with State and Federal MCH efforts. No one knows that better than you. As a pediatrician, I applaud your efforts to improve access to care, to promote infant, child and adolescent health, and to address all the other urban health concerns which make an enormous difference to families and children.

Your efforts also are of national significance. Whether we achieve the Year 2000 Objectives for the Nation depends largely on your success in our nation's cities.

Urban Children in Need: Responsible and Responsive Leadership

Monday
September 19, 1994

Margaret A. Hamburg, M.D.
Commissioner
New York City Department of Health

I have been asked this morning to provide a local perspective on the health needs of urban children and families, and to offer some thoughts on how, together, the public and private sectors can most effectively seek and implement solutions. The task before us is not an easy one. We all know that health is but one of an array of many serious problems that confront our nation's children and youth, problems such as inadequate education, family disruption, homelessness, drug abuse, violence ... poverty. All of these issues are terribly important and very intertwined, and perhaps no where can these multiple influences be more clearly and poignantly witnessed than in a major urban center such as New York City.

In order to give dimension to the challenges we face, I would like to begin with some statistics:

- Approximately 1.8 million children and youth between the ages of 0-19 live in New York City.
- About 60% of these individuals are Black or Latino.
- According to the last available census data, at least 1/3 of New York City children live in single parent families and the figures are probably higher. Sadly, an increasing proportion of children have lost both parents to the overlapping epidemics of AIDS, substance abuse and violence.
- And poverty is on the rise. Today, more than 40% of children in New York City are living in families below the poverty line and another 20% are near poor, making a total of 60% of children in our City who live well below the standards of the middleclass.
- Related to this, approximately 1/3 of New York City children are receiving Medicaid and nearly another 1/4 are uninsured.

Against this demographic backdrop, let me mention a few indicators of the health status and health needs of New York City children today:

- Infant mortality, a traditional measure of child health and society overall, is about 30% higher than the national average. What is more, in certain of our poorest neighborhoods, the rates are substantially higher, for example, an astounding 26 per 1000 live births in Central Harlem last year. Correspondingly, there are marked racial disparities in infant mortality, with rates among blacks being about twice that for whites.
- Very much linked to infant mortality are the problems of maternal substance abuse and AIDS. The crack/cocaine epidemic that began in the mid-1980s has taken a terrible toll on mothers and their children. Happily, the use of crack appears to be declining, but the problem of maternal drug use, both cocaine and heroin, not to mention legal drugs such as alcohol and tobacco, remains severe.

Importantly, drug use has been a gateway for HIV transmission to mothers and their children. Some 1 in 83 mothers who give birth in New York City are HIV-positive, and close to 80% of pediatric AIDS cases are due to injection drug use - either by the mother or her sex partner. Strikingly, over 90% of pediatric AIDS cases are Black or Latino children. High rates of congenital syphilis represent an additional serious health concern, also closely associated with maternal drug abuse.

- Although prenatal care cannot prevent all disease and deaths in infants, we know that adequate prenatal care can have a strong, positive impact on birth outcome ... and is cost effective. Nonetheless, a large percentage of births in New York City, perhaps as many as 15%, occur to women who reportedly received late or no prenatal care.

- Our health care delivery system also fares poorly when you look at immunization. A recent survey of immunization status of preschoolers in New York City found that only 40% of the children had complete immunizations by age two. In recent years, we have seen the consequences of this underimmunization in the form of serious measles outbreaks, as well as whooping cough, rubella and mumps.

Moving on to the later childhood years, for the majority of New York City's children, childhood remains an apparently healthy time. Nonetheless many serious health problems exist, and importantly, health related behaviors are being established for the future.

Mortality rates are perhaps not the most relevant indicators of health status among children and adolescents, because thankfully, the numbers are relatively low, but the leading causes of death do provide some important insights and reflect some disturbing trends:

- Leading causes of death among younger children reveal that the major causes are preventable injuries and AIDS. Among children in the older age groups, injuries, intentional and unintentional, also rank extremely high among the causes of trauma and death.

- Particularly striking in the 15-19 age group, is the fact that the major cause of death is homicide. There are approximately six murders per day in New York City, and violence, like virtually every health indicator, disproportionately burdens poor, minority individuals. If current trends continue unabated, it is estimated that a young black male growing up in New York City has about a one-in-25 chance of being murdered before he lives out his adult years.

Looking not at death but at serious illness; hospital discharge data indicate that children in New York City, across all age groups, experience rates of hospitalization greater than the national average.

Asthma presents a good example. For reasons that remain unclear, rates of childhood asthma in New York City, and certain other geographic areas, primarily urban centers, are markedly higher among Blacks and Latinos. And in New York City, higher admission rates for childhood asthma are more than double the national average.

Clearly, improved access to primary care would help to reduce these numbers. As you know, too often poor children in New York City, and other cities, use emergency rooms as their primary care provider; and too often this results in problems not being addressed until it too late, until disease has substantially progressed, and until a potentially preventable condition requires hospitalization.

Nonetheless, it is estimated that in New York City there is a gap in the primary care services available to children of at least 1 million visits. Looking at the gaps in primary capacity in another way, a survey done several years ago in New York City found that in nine low-income communities in the Bronx, Manhattan, and Brooklyn, home to 1.7 million people, there existed only 28 physicians practicing genuine primary care.

Other important gaps in services exist, for example, in family planning and prenatal care, especially for poor women. Important gaps also exist in the number and type of mental health services needed and available.

Clearly, for those children who suffer frequent bouts of acute illness, as well as those with chronic physical problems, there is an increased likelihood of behavioral and social problems. But beyond that, we must recognize that adequate attention to the needs of children requires that health care deal equally with psychosocial and physical disease. In New York City, like in many urban centers, large numbers of children live in environments where sources of stress, anxiety and depression abound. What are the implications for health when a child lives in a community where the streets are unsafe, or where home-life is disrupted by drugs or violence or both?

These are difficult issues to sort out, and made more complicated by the fact that many of the problems, their roots and their solutions are intimately intertwined with problems that fall outside the traditional province of medicine and public health. Clearly, there is much we can do to better provide needed health services to children. But, at the same time, a complex array of social and economic factors, including poverty, drug abuse, family disruption and inadequate education greatly influence the health of our children.

So how do we begin to address these serious, pressing problems? How can we begin to meaningfully improve the calamitous state of children's health in so many of our urban centers? And what are the respective roles of the private and public sectors toward this end? While the list of statistics and disease indicators I just gave certainly masks the human face of the problem and cannot give us an accurate overall picture of the health, or ill health, of children, I think that they help to illustrate for us several salient themes, perhaps imperatives:

1) The over-riding importance of prevention;

2) The need to more effectively, and equitably, deliver basic health care services that we know make a difference;

3) The need to address present needs and realities in the lives of poor children and their families,including inadequate access and lack of quality care, but also social disadvantage and economic deprivation, while at the same time working toward the basic right of health care for every child and a system of services that makes that right a reality; and,

4) The urgent need to press on in addressing these problems, despite the terrible fiscal crises enveloping so many of our cities.

These concerns, and hopefully commitments, emerge quite clearly from the data, and I believe that they pretty much speak for themselves. Yet, I want to underscore their importance, and their interconnection, as well as to identify some of the future directions in which we should be guided. A quick glance at the numbers confirms that the majority of ills we are struggling to surmount are potentially preventable (in terms of either preventing onset of disease or disease progression or both) with appropriate primary care and preventive health strategies.

Not only can we save lives, but we also can save money. You are probably all aware of the estimate that every dollar invested in immunization saves some $14 in medical costs, yet why is it that New York City and the rest of the nation, continue to have immunization rates lower than those in many developing nations? Similarly, we know that prenatal care is both cost-effective and essential for improving the health of mothers and infants, yet again our efforts are distressingly poor, and in turn, our rates of infant mortality a matter of local and national shame. Why is it that asthma, a condition that can be effectively and relatively inexpensively managed on an outpatient basis, accounts for more than 10% of hospitalizations for New York City children?

The problem is that we have not invested in the kinds of preventive and primary care services that we know make a difference, and we have not applied all of our current medical knowledge and tools to address the problems at hand.

Sadly, nowhere is this more apparent nor more acute than in New York City, a city that can boast one of the greatest concentrations of sophisticated biomedical institutions and affiliated clinical facilities found virtually anywhere on earth, including seven medical schools, 75 hospitals, nearly a third of a million health care workers and annual health care spending of some $30 billion dollars. Nowhere are the fruits of modern medicine more in evidence than in New York City's concentration of premier medical institutions, yet so many of New York City's communities speak to our egregious failures.

Given the magnitude of both the human and fiscal crisis to which we must respond, it is obvious that an essential element of an effective urban strategy to improve child health must be to improve access and build capacity to delivery primary care and clinical preventive services to all who need them.

An important part of this is of course financial and current machinations here in Washington suggest that the much desired national health reform goals of universal coverage and a minimum benefits package including preventive services may be illusory. Nonetheless, on a local and state level there are examples of where we have made some notable gains in terms of expanding and extending coverage for children, and there are opportunities to do more.

With respect to financing, an additional, important real world hurdle is to ensure that kids who are eligible for Medicaid or other such programs actually get enrolled in the current system of financing health services. A surprising number are not enrolled, and the barriers to registration are many: slow, frustrating bureaucratic forms and procedures; separate, often distant sites; language barriers; transportation and child care issues; fluctuating employment status, and many other reasons.

An important first step is to reduce the complexity of the process. I am pleased that New York City, largely thanks to the efforts of the Children's Defense Fund and a committed cadre of child advocates and government officials, the Department of Health and others are embarking on a trial program to introduce a simplified form (from 30 pages plus to about five). Though admittedly a small step, I believe that it will result in enormous improvements in Medicaid enrollment.

Yet, we all know that improved access is more than just financial coverage. Beyond financial concerns, overcoming barriers to care will require appreciation of and attention to such issues as supportive services (eg. patient education and social services) and certain enabling services (such as help with transportation, child care, language translation and cultural sensitivity). In addition, home care, as well as active outreach in many communities, are essential adjuncts to ongoing patient care, particularly for children and families with special needs.

And perhaps most fundamentally, we need to strengthen and expand primary care capacity. Although many factors contribute, one of the most profound obstacles to primary care faced by New Yorkers is unfortunately a lack of doctors and other critical health care providers. We also must continue to build the facilities needed to deliver community-based primary care. It had been my hope that national health care reform would offer the opportunity to develop the much needed incentives to increase training of primary care providers and dollars for infrastructure building. However, since the prospects for meaningful reform grow increasingly dim, we must aggressively examine other strategies for achieving these important goals.

In this regard, New York City has put in place an exciting program that holds great promise. The program is called the Primary Care Development Corporation (PCDC), and it is a not-for-profit corporation designed and instigated by city government, but now free-standing with foundation support than can offer low cost, tax-exempt capital financing for primary care providers, through a financing mechanism that includes the city offering credit support and the creation of a development pool. The first round of awards was just made to 16 providers, targeting the most underserved communities throughout the city, and reflecting an array of provider types, including hospitals, community health centers and some community/provider partnerships.

We are very enthusiastic about this program, and optimistic that over the next year as a result of this program we will see significant expansion of primary care and in the communities where it most vitally needed. Improving the health of children and youth requires that we reorganize and refocus our health care delivery system, including building a network for primary care as just discussed, but it also means a renewed commitment to our infrastructure for public health programs and services.

In the minds of many, public health and health departments are about providing health care to indigent populations, and historically, we have been important and effective providers of last resort. But we cannot afford to have the broader functions of public health overlooked; we cannot neglect the important contributions to the health and safety of children and youth of such core public health functions as: surveillance and control of communicable and other diseases; protection from environmental hazards; health education and disease prevention programs; and patient-specific disease control interventions.

Many of these activities do not occur in a doctor's office or in a clinical setting, yet they are unarguably vital to the health and well-being of the people of my city and of this nation. Disease surveillance, for example, serves both as a sentinel alerting us to new or re-emergent threats, and a research tool enabling us to quickly devise interventions that stem the spread of disease. To relax surveillance, particularly now, as the erosion of geographic barriers and complacency about certain practices has made the introduction of disease threats more likely, is to let down our guard and imperil our people.

In addition, the formidable epidemiological tools of public health can be employed to gain deeper understanding of, and devise interventions for areas of great concern for our nation's youth, such as violence and injury prevention, that traditionally have not been considered health issues.

Public health programs and services are ideally situated to reach populations at high-risk for a range of health problems. Many of our outreach and community based programs offer opportunities for prevention and early intervention that are cost-effective and deserve support and expansion.

Through health education and promotion efforts, public health also has achieved success in changing behavioral patterns involving tobacco and alcohol use, diet and exercise. The benefits of such change are difficult to calculate precisely, but they are obviously immense, whether measured in decreased human suffering or economic losses averted.

Population-based public health prevention programs have also had profound influences on social policy and have been credited with reducing many health risks. With respect to children and youth, activities in the arena of enhancing automobile safety and initiating other injury control measures are good examples. Such efforts have led to significant declines in overall death and injury rates in this population.

Certain environmental issues of great concern to children, among them lead poisoning prevention and protection of the food and water supply, are the responsibility of public health, again enabling us to protect health rather than treat disease. Many of these functions are critical and unique. What good does it do for a child to be screened for lead in a doctor's office if there is no mechanism, when a blood lead level is elevated, to identify the source of lead exposure and have it abated? Better yet, we can work with parents and communities to educate them about the possible sources of lead exposure to young children and work together to reduce or eliminate them.

Indeed, these public health interventions reflect public health's role as "physician to the entire population." Not only are public health activities essential for attaining our national and local health objectives, but, as the proverbial "ounce of prevention," they collectively represent an extremely cost-effective element of national and local strategies.

Any realistic agenda for improving the health of children and youth, must contain a commitment to public health, along with primary care and preventive services, better integration and coordination of existing health care services and improved linkages with mental health, substance abuse and social services.

In fact, the elements of a broad-ranging, realistic child health agenda are not elusive or mysterious. A range of commissions and reports have elaborated on many of the objectives; many have set forth recommendations for action. There are incremental steps that must be taken, and some have been. To a large degree, we know what to do, so how can we be more effective at getting it done?

First, and perhaps most obvious, those in authority, those in leadership positions and those with influence must make sure that these issues are put squarely on our local and national agendas. We must convince not just politicians, but the body politic itself, that the issue of protecting our children and promoting their health and well-being is a matter of real urgency; that perhaps no other investment has such serious, long-lasting implications as ensuring our children, and truly our nation's, future through a commitment to improving their health, education and welfare.

As the chief health officer of a major city, fraught with problems, but also many possibilities, I feel that advocacy must be an important role. Along with my many colleagues in health leadership positions throughout the country, and along with all of you in this room, we cannot be discouraged by setbacks in national policy around health ... and hard as it is, we cannot be discouraged by the fiscal and operational problems we face day-in and day-out on our jobs back home.

And in coping with the serious human problems of these children and their families -- health problems, social problems, economic problems -- we must be prepared to re-examine old premises and to encourage innovation; we need to look at new ways of providing services and designing programs. Reports such as Starting Points offer us a valuable opportunity to focus on new approaches and to explore alternative strategies already being tried and working elsewhere. Often, when confronted with the many, complex needs of urban children, all of us, the public, policymakers and providers alike, are tempted to throw up our hands in despair. Yet when our composure returns, it is encouraging to see that there are programs that, in fact, make a difference.

On many levels, it is extremely helpful to be able to look at and learn from programs that work. They can guide our own program development across a range of areas and help us to more effectively utilize what is an increasingly limited dollar.

Clearly, we need to continue to identify, expand and extend such activities for the greater good and health of our children. This requires partnership, through information sharing, resource development and evaluation, and it requires broad collaboration. The public and private sectors, and instrumentally foundations, must share this vision to make it happen.

Looking at the complex problems before us, we can all agree that real solutions will require us to address and integrate the many underlying medical, social and economic factors that intersect to influence health. Yet this demands an extraordinary degree of collaboration, not just within the fields of medicine and public health, but also across a range of disciplines and among many different kinds of agencies and organizations.

Such collaborations are difficult, and worsened by the funding, educational and organizational realities of the systems in which we work. I am sure that all of you have experienced some of the frustrations in trying to collaborate, even around issues so urgent and compelling as the needs of children and youth. Categorical funding streams, organizational rigidity and loyalties, professional education and traditions, inadequate resources and the fact that so many of us are already stretched to the limit so that taking on one more thing threatens to overwhelm... All of these are reasons why well-intentioned and much needed collaborations often do not get off the ground.

Here again, I believe that foundations can play a powerful role. Their efforts, reflecting an array of potential strategies from convening meetings, to assembling blue ribbon panels, to producing reports or supporting demonstration projects, can help devise road maps to navigate some of this difficult terrain, can help bring people together in new ways and can help develop innovative new approaches.

All of these must be explored, our facilitating effective collaboration is essential to any strategy to improve the health and well-being of children and families. And in this regard, I would be remiss if I did not say a word about the vision of Magda Peck in creating the CityMatCH organization and initiating conferences such as this one. By providing a forum to unite individuals with different backgrounds and experiences, but with many similar responsibilities, shared interests and concerns, you have offered a powerful opportunity to come together around common problems and together seek our meaningful, enduring solutions.

I thank you, Magda, for both your vision and your commitment. And, thank you for giving me the opportunity to share this program with my father, whose vision and commitment, and whose wisdom and quiet good humor, has long been a source of both pride and inspiration.

National, Federal, State and Local Approaches to Implementing the Childhood Immunization Initiative

Monday
September 19, 1994

State Leadership in Immunization

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I am delighted to be with you to share a few thoughts on the role of the states in providing leadership in the immunization effort. First, I need to define leadership. Leadership is taking risks, it is identifying an issue, a position or a policy and getting in front and then convincing others you are headed in the right direction. Leadership is not figuring out where the herd is going and then running to get in front. It may be good politics, but it isn't leadership. Leadership can be dangerous. Leaders not only catch arrows from the enemy in front but also from the friends behind. If a leader fails to convince the group he/she is headed in the right direction, it gets very lonely being all by yourself. But despite the risks of taking charge and becoming a leader, leadership is something public health in general and the states in particular have always practiced. I would like to begin by focusing on some examples of leadership by states in the immunization effort.

Many states made the decision to purchase vaccines for all their children before the current and most recent interest in immunizations. States such as North Carolina and Rhode Island are two such examples. But even in an area as apparently noncontroversial as providing vaccines for children, there are still pitfalls. South Carolina made an effort several years ago to become a universal purchase state; however, despite good preparation and planning, other factors beyond their control intervened to prevent universal purchase.

States across America have undertaken specific actions to improve immunization levels. The Childhood Immunization Initiative (CII) and the development of Immunization Action Plans (IAPs) have served as catalyst for many of these efforts.

Many of us have worked to develop community involvement in our immunization activities. We have come to understand that simply providing vaccine and giving shots will not get all children immunized and will not eliminate vaccine preventable disease. Communities must be involved in this process. Immunizations must become something parents value and expect. While we in public health struggle to involve partners in the immunization effort, we must always remember that while we can share resources and opportunities, we cannot share ultimate responsibility. For ultimately it is the public health system that is responsible for preventing the occurrence and spread of vaccine-preventable diseases. Thus, an area of state leadership must be to clearly define the roles and the responsibilities of our partners in these initiatives so that no false expectations are created.

While all of us over the past years have worked to develop community support, other more specific actions have also been undertaken. Texas has recently earmarked millions of new dollars to ensure the immunization of its children. It has launched an ambitious campaign called "Shots Across Texas" with publicity and fanfare. This is another example of when leadership sometimes causes problems. At the time Texas and other states developed these initiatives with their own local populations in mind, a federal initiative was also launched. While this initiative was designed to enhance and strengthen local efforts, many of us in states were concerned that the federal effort would only confuse citizens with two slogans and two 800 numbers. Others, including Alabama, have developed incentive campaigns with T-shirts, McDonald's coupons, and other incentives for receiving or completing timely immunizations.

With the additional funding from IAP, states have been able to not only develop coalitions, expand outreach and education but perhaps most importantly, increase access to immunization services. States have taken vaccine efforts into housing projects, after-hour clinics, Saturday clinics and shopping malls. In Birmingham, Alabama, the local health department set up immunization services at an amusement park. Not only has building community support been helpful in changing community and parental expectations, it has also (at least in my state) provided a new source for vaccination. The local National Guard decided that helping immunize children in rural Alabama was at least as good a training experience as giving shots in Central America. While working with this new partner has had an occasional rough spot, it has been well worth it because of the additional services made available for Alabama's children.

The Childhood Immunization Initiative and the development of IAPs have served to spearhead the development of greater community involvement, increased outreach and education, provided incentives for immunizations, and funded expanded clinic hours and sites. Perhaps the most important effect of the renewed emphasis on immunization has been not so much to change the general community as to change us, the public health community.

The outbreaks of measles in the late 1980s and early 1990s were not in large measure due to a new super bug. True, some of the measles on college campuses was due to primary or maybe secondary vaccine failure; but for the most part, measles was occurring in unimmunized preschool children. Was it a surprise to health departments that these children were unimmunized? No! Was it a surprise that children unvaccinated exposed to measles get sick? No! So what is the explanation? We (especially those of us born after the polio epidemics) had just gotten complacent. We had other problems--AIDS, infant mortality and others. We couldn't be bothered just because a parent didn't get a child his/her shot. would we accept the same excuse about a TB patient who didn't come in? Of course not! Many of us at the state level were shocked out of our cocoon of denial by the measles epidemic.

Many of our initiatives don't require dollars, they just require will, work and effort--dollars are easier. In Alabama we quickly identified obvious areas where we were simply failing to maximize immunization efforts--like failing to screen WIC children for immunization needs, failing to give simultaneous vaccinations and missing opportunities due to false contraindications. Without new dollars but with a new commitment beginning about four years ago, we have been able to increase our two-year-old levels from 58 percent age appropriately immunized in 1988 to 76 percent in 1994. And, the level in the public sector is now higher than the private sector. These changes came about before IAP or CII. It just took commitment.

Now let me turn to a final issue in closing--the VFC. VFC has not been a program that has had universal support from the states. Many of us are very concerned about the complexities and potential confusion which this program may cause. Most of the states would have preferred a universal purchase program so that we could have used state dollars not for vaccine purchase, but rather for infrastructure support. Nevertheless, this is the program we have and we will make it work.

There are certainly parts of the VFC that states strongly support. We are excited about the prospect of immunization as an entitlement for children. States who often use up to 40-50 percent state dollars to purchase vaccine for children strongly support the right of states for unlimited optional purchase from the federal contract at reduced prices. This is essential so that states who wish can exercise the option of purchasing vaccine for all their citizens, irrespective of income. We have been pleased about the willingness of CDC to work with states to minimize paperwork in both the public and private sector. We feel that keeping paperwork to an absolute minimum is essential if we are to have significant private provider participation. Many health department clinics are today filled with children referred from private providers for immunizations. This is less than desirable care for the child since it promotes discontinuity of health care and disrupts the medical home. It is also problematic for public clinics by filling space with patients who could be served elsewhere.

While we applaud these positive elements of the VFC, there are areas with which states take exception. While the paperwork has been kept to minimum, the requirement that some effort be made to determine if a child has insurance, if that insurance covers immunizations coupled with the fear that someday an auditor may want to review these determinations, concerns states and will, if not carefully implemented, do serious harm to this program.

States are especially concerned about the requirement that "underinsured" children can only receive VFC vaccines at Community Health Centers. First, what is an underinsured child? Isn't that a lot like being "a little pregnant?" The truth is a child is either insured for immunizations or they are not; thus they may be uninsured for immunization, they are not underinsured. The idea of a public health agency identifying a child as being in need of immunizations and then having to refer them across town to a Community Health Center to get that vaccination because they are "underinsured" is abhorrent. That means we are to hope, pray and assume that they will go and keep the appointment. Never mind that they may have paid $5-$10 for a friend to bring them to the clinic in the first place. This is the sort of complacency which allowed measles outbreaks in the first place. No better reason can be found for the necessity of state optional purchase than that scenario. States must be able to purchase vaccine at low prices (from the federal contract) to immunize these children in public clinics and to give vaccine to private providers for use in their clinics. This is right for the children and it is correct public policy.

With October 1 closing in and the start of the VFC imminent, it has been with growing distress that we have watched efforts being made to change this program. First, a national warehouse which was to be used for distribution was canceled by the administration after a GAO report. Unfortunately this left approximately half of the states unsure about how to get vaccine to providers, especially in the private sector. But despite this unexpected problem, some states have decided to develop their own distribution systems for the private sector all in a matter of days. Despite uncertainties about how vaccine will be distributed, we continue to recruit providers because somehow we will make it work; we have no choice.

Now after surviving that crisis, talk in Congress is of technical corrections to VFC. Considering the impact of some of these proposed changes, calling them technical corrections is like calling the sinking of the Titanic a "boating mishap." The proposed changes would, among other things, increase accountability and reduce the ability of the states to purchase vaccine from the federal contract. Let me assure you that the state health officers are very supportive of the vaccine industry and we recognize the need for a reasonable profit margin to support research and development. We have no desire for the VFC program to destroy the private vaccine market. However, we cannot and will not support some of these proposed changes. We will not support changes that so increase paperwork and bureaucracy in the name of accountability that private providers won't participate. We must increase vaccine delivery in the private sector.

Second, states cannot see their ability to purchase vaccine at reduced federal prices so restricted that we are unable to buy non-VFC vaccine for use in our clinics or to distribute to private providers for the "underinsured." Failure to protect this right could, in fact, further fragment health care for children and reverse the progress we've made on immunizations. Certainly the best solution to the problem of the underinsured is legislation guaranteeing to all first dollar coverage for immunization. That would eliminate this group entirely.

I would like to close by again noting that leadership is not without risks. Whether it is at the state level, federal level, or local level, getting in front sometimes makes one a target. But when the cause is the health of America's children, I can think of no better reason to be a target. Reaching a goal of 90 percent of the children appropriately immunized by the Year 2000 will not occur because of the states, the federal government, local health departments, parents or communities. This goal can only be reached by working together in a true partnership. The Year 2000 is only 6 years away, we must get on with this work. Let's go lead. Thank you.

Violence and Public Health: Problems to Policies

Tuesday
September 20, 1994

The Honorable Ellen Anderson
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St. Paul, Minnesota

This talk is about using data and research information to create good public policy. While data and statistics are often used to put audiences to sleep and to disguise the emotional content of factual situations, statistical data can also be used to grab one's attention in a powerful way. One of the most compelling examples I heard recently came from a school administrator talking about the fact that we don't value our children very much in the United States. He said that in this country it is more likely that our dogs are inoculated than our children, and that we spend more on cat food in this country than on school textbooks.

As a first-term state legislator, I can tell you from personal experience that I don't believe we make nearly enough use of cold, hard data and research in making our public policy decisions. You have all heard the old line about how it's equally unpleasant to watch laws being made as sausage. Believe me, I can vouch for the fact that a great deal of our law-making is about as based on rationality and factual data as are the horoscopes in the morning paper (I apologize to anyone in the audience who is a fervent astrologist).

Unfortunately, the issue of crime and violence, and what to do about them, is one of the worst culprits for policy-making based on fears and demagoguery. Although the Minnesota Legislature has a well-deserved reputation for some of the most innovative, progressive policy-making in the country, we are subject to the same political pressures to increase penalties and build more prisons, without any rational basis for believing this will make our people safer in the short or long run. However, after my two years in the Senate, my sincere hope is that we can step back from the usual path, closely examine all the data and research that exists, and put it to work crafting crime prevention policies that truly have a hope of reducing crime and violence for future generations of Minnesotans.

Minnesota Efforts

I would like to tell you about one of the ways we are trying to achieve these goals in Minnesota. During my first session, in 1993, I had some discussions with a lobbyist for United Way about the origin of a statistic we had both heard used repeatedly: that something like 90% of men in prison were born to teenage mothers. We did a little investigating and found that nobody seemed to know where it came from or who said it first. I had saved a newsletter from some local organization that cited the statistic, but when I called them they couldn't track down its source either. We started talking about the need for some real data, Minnesota data, that could help us determine who is in prison and why those particular people end up in prison. I was successful at getting the Legislature to pass my Inmate Survey bill with a totally inadequate appropriation of $25,000. Luckily, some local crime prevention organizations -- the Citizens Council and United Way -- as well as a respected University of Minnesota social scientist, Dr. Jane Gilgun, got excited about the project and ended up doing a very comprehensive survey of 1700 inmates, about 100 women and 1600 men, out of a total prison population of about 4000, from all Minnesota prisons. They used the concept of risk factors and protective factors during childhood to organize the results, and compared the inmates on key risk and protections with three other control groups, including large groups of non-inmate adolescents and adults. The researchers believe it to be the first study in Minnesota and possibly the nation to identify both risk and protective factors in the lives of prison inmates. (The study A Survey of Minnesota Prison Inmates: Risk and

Protective Factors in Adolescence, has been released and is available by contacting the Minnesota Citizens Council on Crime & Justice, 822 South Third Street, Minneapolis MN 55415, 612/340-5432.)

Let me first back up and explain some of the research this study was patterned after. Dr. Peter Benson of the Search Institute in Minneapolis has identified a list of "assets" and "deficits" that correlate with emotional well-being or with high-risk behavior, depending on which a young person has more of. The inmate survey reflects other research based on some similar concepts, that indicates a correlation between high risk factors, low protective factors, and the likelihood of being involved in criminal activity. Examples of important protective factors are close relationships with positive role models, opportunities for education and jobs, etc.

The most significant finding of the inmate study was that the one factor that most distinguished inmates from non-inmates was the likelihood that they had someone in their life they discussed their problems with. The most important risk factors, which inmates were much more likely to have than comparable non-inmate populations were physical and sexual abuse, poverty, and low parental education. Out-of-home placements were very high among inmates during childhood and adolescence. But contrary to popular belief, most inmates were not born to unmarried teenage parents.

Inmates also had protective factors in their childhoods and adolescence. For example, most inmates felt care for by their parents and did not differ significantly from non-inmates in this regard. Yet, inmates experienced risks which overwhelmed protections and the risks appeared to "pile up," making them more likely to have negative behaviors or outcomes.

Having Learned Some New Things About Prison Inmates, the Question is How We Can Use this Data to Build Good Public Policy?

I have three suggestions which I will discuss one at a time. **First, as we present data to the public and to the legislature, we have to answer two basic questions to persuade them it's important and relevant data, especially because statistics are so often misused:**

A. We have to be able to state convincingly that changing the characteristics of people as recommended by the data will, according to statistical probability, in fact reduce future violence.

B. We must be able to state convincingly that law or policy can accomplish the recommended changes in individuals.

To better explain what I mean, I'll refer back to the Inmate Survey. I had two questions for the researchers that we would need to answer for legislators. First, is it valid to say that if we reduce the risk factors and increase the protective factors in any given population, would we be accurate to predict that criminal behavior will be reduced in that population? In other words, is there a cause and effect relationship? Based on the data, can we say that we know how to reduce crime and violence?

The second questions for the researchers is, is it possible to affect the risk and protective factors in populations by changing public policy? Well, the social scientists were very cautious about answering the first question, and would only go so far as to say that there is a statistical correlation between these factors and being an inmate, so the population should be statistically less likely to be inmates if we increase their positive factors and reduce their negative ones. That's good enough for me, and I think it should be good enough for legislators and the public.

As to the second question, is it possible for us to affect a child's risk and protective factors? I believe it is, but I think this is an area in which we are lacking good data. There has been a push in recent years by "good government" types to improve our evaluation of our government-sponsored programs. In Minnesota we have instituted various reforms which have the purpose of compiling information to evaluate outcomes. But, I don't think we have enough comprehensive information about which types of intervention in children's lives increases their protective factors or decreases their risk factors.

But some of this just takes common sense. Obviously, policy makers cannot pass a law mandating that every child has someone they trust to talk to about their problems, but we can fund and promote big brother/big sister programs and adult/youth mentor programs, and we can mandate better training for school counselors and teachers and others who routinely deal with children how to recognize whether a child needs someone to talk to and how to teach boys it's all right to talk about their feelings. These are such simple, humane, and affordable steps that it seems it should be an easy matter to get legislative support for them.

The second part of an effective strategy for changing public policy is that we have to shatter myths that are used to justify our existing policies. Here's an example. Most of the public fear about crime is associated with random acts of violence perpetrated on people on the street or in break-ins into their homes. Senior citizens feel afraid to walk their neighborhood streets. But look what we learned in Minneapolis in their recent Kidstat Public Health report: The most shocking statistic in there is that the highest homicide rate in the city is for infants under the age of one.

This should point our policy-making in a different direction, both for political reasons and for fact based reasons. If the public understands the threat is greatest to the most vulnerable tiny citizens in their own homes from their own families, that gives politicians more freedom to devote more time, resources, and rhetoric to the problem. The information leads us to different conclusions about how public policy should be formulated to reduce homicides: perhaps instead of more police on the streets, we need more social workers and public health nurses making in-home visits. Instead of targeting gang members, we need to target families that are stressed and provide respite care for their children while the parents take a break.

The third part of the strategy is to build public support. This requires the media to stop exploiting the crime problem and the public to stop demanding candidates to be tougher and tougher on crime. I think the key is more education and public awareness. Last session I authored a bill to create a Violence Prevention Task Force, which is mandated to define violence prevention, set violence prevention goals for the state, and advise the legislature how to make violence prevention policies part of its work. We plan to survey all of the research out there, survey all of the violence prevention efforts currently going on, and report on where all of our state crime dollars go.

I believe a key to success is getting as much media coverage as possible, and building public understanding and support early in the legislative session, so lawmakers will take notice. We have assembled a dynamite group of people, including one high-profile TV anchorwoman, and others who we hope will draw attention to what we are doing.

Another Part of Building a Community Consensus Requires Us to Listen to the Experience of Communities.

The violence prevention task force is collecting information from all over the state, from local groups working on violence prevention in schools and communities. Research and laboratory tests of social science theories are important but the real test of their validity comes with practical application. Only with experience can you answer questions, such as how can a community go about building resiliency or protective factors in children? What really works? What kind of intervention are families really willing to accept in their homes?

This is important not just for testing the theories but also for political reasons. Grassroots support for changing public policy is one of the strongest assets a legislator can have. Other legislators will listen carefully to active community members who happen to also be voters from their legislative districts.

What are the Chances of Succeeding?

As I hinted at the beginning of my talk, I am rather cynical about the frequency with which law-making is based on rational facts and data. In Minnesota I think we could easily go in either direction. Right now we are in the middle of a Governor's race. The liberal Democratic candidate is proposing a tax increase on the wealthiest 4% of Minnesotans to pay for children's programs like Head Start and child care. He argues that if we don't pay now, we will spend far more later. The newspapers and his opponent are gleefully exploiting his honesty about proposing a tax increase and the public may not be convinced to elect the governor with the "investment strategy." Here in Washington, you witnessed firsthand the rhetoric surrounding the crime bill which reduced its efforts at preventing crime to "pork." I hope we can have a more rational debate in Minnesota.

There are some factors working in our favor. We certainly have a number of legislators who fight hard for prevention policies every session. Two years ago, some of them were successful at getting the Legislature to commit to putting a dollar into prevention for every dollar into prisons or punishment. During the 1994 session, this commitment fell by the wayside as it did all across the country, and Minnesota invested in its biggest prison expansion in history.

Based on another major legislative battle we had last session, over the storage of nuclear waste and our state's future energy policy, I also have faith in what could be called a "New generation" of legislators: many newer, often younger, often women legislators who are willing to take tough votes against politically popular ideas that really don't serve the public well in the long run.

We are going ahead with our plans to present the Violence Prevention Task Force report and the Inmate Survey report to the legislature, and we hope the media will pay attention. If we can get some of the numerous community groups working on prevention efforts to rally around our proposals, that will significantly increase our chance of success.

Conclusion

Even if we are able to win change in public policy based on new data, I fear that it will be accomplished piecemeal. In my view, good policy changes like the ones I have suggested will not accomplish the predicted result unless they are universal and long-term. The types of recommendations I've discussed also leave out some of the most important factors that relate to the stability of families and their children: housing, poverty, availability of jobs, etc.

My dream would be for Minnesota's Violence Prevention Task Force to be able to issue a comprehensive report that plans for a whole generation. I would like to be able to present a 10-year plan or 20-year plan to the Legislature and tell them authoritatively: if you pass these policies and fund them fully, we will have 50% less violence and 50% fewer violent crimes in the State of Minnesota 20 years from now -- and here's the proof. For example, if we want to serve X number of children, we need to spend X dollars on providing positive adult mentors for each one, at a total cost of X. Multiply this by every other necessary program and the result in that population will be X amount less likelihood of violence.

This kind of a comprehensive formula is hard to come by and if it does exist, its validity may be subject to question by even the most ardent statisticians and social scientists (not to mention politicians). Of course the cost of such a proposal would be high, but I think our research can show conclusively that over the next 20 years it would be a money-saving policy for our state.

I personally believe this would be the most persuasive type of argument to help change our present course and the most persuasive type of data to support such a change. I would like to ask all of you a question. How far do you believe we can go in predicting and changing human behavior by social engineering or by public policies? Do you believe if we apply the right mathematical formula and the right research and data to our public-policy-making that we can change the course of human events?

I will close by saying that however you or I would answer that question, as a person and as a politician I must make it clear that I believe our obligation is to use whatever humane means we have at our disposal to reduce crime, violence, and all of the human suffering that results.

Local Public Health Leadership in Times of Transition

Wednesday
September 21, 1994

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How long does it take a vision to become a reality? Well, many factors will determine the answer on a case by case basis. Fifty years ago, in 1944, the then surgeon general Thomas Parron, signed the Public Health Service Act into law. This law foresaw the need to develop an integrated system, which insured personal care and well financed public health programs, that compliment and support each other. Fifty years later, the public health community will most probably see Dr. Parron's vision realized.

What's in it for local public health?

Government became engaged in public health, because there was a public concern for the general welfare, safety, and health of the people. There is a unique role for government public health practice at the local, state and federal level. Their responsibilities are different, from other public health agencies because they are governmental entities. You have a document in your folders entitled "Blueprint for a Healthy Community, A Guide for Local Health Departments." I would encourage all of you to read this document at some point. It's not meant to be a cookbook, but merely a springboard. In the "Blueprint" there is this quote, "We must be certain that the unique responsibilities of government are well expressed, and operationalized in the current environment and structure. As foreboding as the uncertainty, of how the future legislation, as it will craft healthcare reform, at the national and state levels and how that impact on us," there are other critical factors in the environment, that will have equal or greater impact:

1. The continuing dissatisfaction of the taxpayer with the perceived status quo of government, at all levels, looms over all of us. We are challenged to make revolutionary changes, in the way we do business as government entities. In the national best seller Reinventing Government, by David Osborne and Ted Gabeler, there are many good ideas that can offer new boundaries and new approaches, while giving you permission to make the changes organizationally, that are necessary to fulfill the core functions.

2. The changing role of hospitals in addressing community health needs, is another uncertainty in all cities. Do you know how your hospitals would define who in your community has responsibility for: 1) Community health leadership? 2) Collection, analysis, dissemination and, the repository of data on your community's health status? 3) Prevention activities?

Hospitals have not traditionally looked beyond their own system as a place to provide health services. Now as networks are developing, integrated/managed care takes hold and the community benefit requirement looms larger than ever for all hospitals, they are beginning to look beyond their traditional boundaries. We need to be able to answer the question posed in the introduction to NACHO's Blueprint, and I quote, "What does it take to create and maintain a healthy community?"

The Healthcare Forum, a think tank organization for healthcare providers with a diverse membership, has just published an executive summary of a national survey they sponsored. The purpose of this survey was to identify a framework that will help define "the way we achieve health" in this country. This framework will be designed using new strategies that will lead toward the creation of health in our communities, rather than strategies that merely improve the way we treat illness. They go on to state in the Healthcare Forum report that the solutions to many of the leading causes of illness and premature death do not rest within our hospitals or medical delivery systems, as currently configured. Many of these solutions rest with socio-economic factors, our behavioral choices, and those practices we encourage (or condone) as family members, neighbors and fellow citizens in the community.

Sound familiar? Health care reform, taxpayer unrest, sharing the community are all good reasons. In fact, THEY ARE THE REASONS TO UNDERSTAND AND DEVELOP CAPACITY TO CARRY OUT THE CORE PUBLIC HEALTH FUNCTIONS IN YOUR HEALTH DEPARTMENT. The Academy of Sciences, in findings from four of their major sponsored reports, unquestionably state a stronger more responsive public health system will be necessary in order for healthcare reforms to succeed. What will it take?

1. Strengthening public health leadership.
2. Enhancing professional competence among public health leaders and staff.
3. Revising outdated local ordinances and state statutes.
4. Filling gaps in data collection.
5. Improving the systems analytic capacity to use data efficiently.
6. Ongoing links between public health, and private sector healthcare for population wide responsibility of public health.

We are all challenged to shift our thinking away from the delivery of personal services towards population based services. As an example, we all know as public health experts, the causes of premature death are attributed to the following: 10% come from lack of access, 20% from inherited or genetic factors, 50% from behavioral consequences, and 20% from environmental. A quick look at this data shows that 70% of the causes of premature death, need to be addressed through population based approaches. These interventions need to address the causal factors influencing a population of behavioral and environmental outcomes. With that as a means of introduction, let me briefly run through some examples of population based services and then talk to you about what the core functions are. You should be familiar with these examples of population based services. The State of Washington has defined them well.

- Health surveillance programs such things as vital statistics, communicable disease reporting, chronic disease registry. Other examples of population bases services: health protection programs; drinking water monitoring; food sanitation; toxic chemical regulations; occupational safety; childhood lead poisoning programs; personal preventive programs, which include immunizations and communicable disease investigation.

- Health promotion programs which include such activities as alcohol and drug education, tobacco control, injury and violence prevention. There are other categories of services which one may question as to whether or not they are population based, but they need to be included as part of the assurance function. These services include information and referral; public health nursing home visits; case management; facilitating resource development; medicaid outreach and the like.

All of you are familiar with the three description words: Assessment, Policy Development and Assurance. I find it helpful to see this as NACHO pictures it - a process cycle. You have a definition sheet in your packet that was taken from a document prepared by NACHO in July 1993. It represents some of the beginning work from NACHO in describing the core public health functions for local health departments.

We all come from different sizes of local health departments. However, there are key roles that local health departments play in partnership with state health departments. I would like to clarify what NACHO considers key roles for the local health department. The local health department is responsible for serving as the collectors of local data. Not only on their own services but others occurring within the community. The state health department helps in assembling the overall picture, developing reference points and trends. In addition to the secondary data, the local health department assesses the citizens' perception of community health status - of what people believe to be the most important health issues facing their community.

Another function of the local health department in the assessment process would be to manage the health resource inventory, to convene public meetings and public forums, to conduct polls, to collect information from the private and non profit providers, and engage in research. A third function, in partnership with the state health department, would be to provide local interpretation and forecast of health data and other related information and serve as a repository of this information for the jurisdiction served.

I cannot stress this element enough.
In my state, the city that I have jurisdiction for is the largest city in the state. It is the headquarters for statewide media services. We are constantly the first contact for the media on any kind of health data that is submitted to the press, whether it is related to our community or not. So, it is critical that you develop a communication protocol with your state health department.

Another key function for the local health department, and I believe the function that no one else can play in your community, is the responsibility to provide the leadership at the local level in disseminating information to the public on the community's health status. It is our responsibility to provide information directly to the news media, community officials, and elected officials, and to publish easily understood reports.

It is our responsibility, after all, to be the unaffiliated organization in the community that can speak objectively to what this data means and how it will play out in our community as it relates to public health. It is not our responsibility to have another agenda when we assume that role. Although tempting, we have to be very careful not to blend our role as leaders and our role as advocates.

The second core function of the local health department is informing public policy. What that means is: depending on the political environment, some of you may or may not have ultimate responsibility for policy development. In my jurisdiction, my elected officials are my Board of Health, and although I may research and write, and shepherd the policy, it will still be their policy. We have to be very clear about where our roles stop, and where they don't. The process of policy development relies on scientific information, and your data from a variety of assessment procedures. You put balance on that information. You make sure that you hear from all parties that are interested in the issue. You develop concepts of political, and organizational feasibility, so that decision makers have a broader scope as to the potential impact. You take into account your community's values, and through an open process you involve all, in the private and public sectors, in policy development through communicating with them, through networking and through building constituencies.

Again, let me try and clarify the difference between what happens at the local level; vis-a-vie the state level. As most of your know, many health policy issues first develop at the local level. Regional or state policy development efforts ought to occur only when local leaders agree that centralized policy development is more efficient and effective and then only with the active participation with communities. This approach is based on the assumption that the strongest public health policy is developed and owned by citizens at the local level. Local health department should provide a leadership role in developing local priorities, plans and partnerships that encompass the entire community. The local health department should also have the authority to initiate, develop and draft local ordinances or rules on health related issues requiring a specific local response. And again, you know how your policy development process works within your own governmental entity. Whether you write it, or whether you rely on your city attorneys to write it, you have to be involved because **YOU** come with the expertise, and can really put the substance into the document that will evolve into the public policy statement.

The third public health core function is the one that we know all so well, and do all so well. That is the Assurance Function. That's where we're making sure that health services are available. We also assure that population based services, whether they be personal preventive services, improved access to care, or health promotion and education programs are available. That's a critical assurance activity, it does not say we must provide it. It says that we should encourage it, we purchase it from others, or we provide it.

The last assurance activity includes maintaining administrative capacity within our own organizations. This would be measured by evidence of:
1) A strong personnel human resources capacity, 2) A very strong contracting capacity because as we move away from delivering direct services we need to have the capacity to be sure that others can do them, 3) A strong financial capacity, which includes a creative financing budget, management and ability to leverage dollars, and 4) Good legal counsel.

Again, to articulate the role of the local health department, your assurance function can be played out by your capacity to advocate, to serve as catalysts, and coordinate organized responses to priority needs in your community. In cases where no other resources are available in the community, local health departments need the capacity to either purchase or to provide directly those personal health care services identified as priorities. Lastly, local health departments, and/or other community organizations, need the capacity to provide population-based health promotion, health protection and preventive health services within the community.

Why should local health departments perform these functions?

I would challenge you all to look at your organization's mission. Why is it that you have the mission that you have, compared to the mission that other organizations, that may seem to have similar services packages have? How are their missions different from yours? I would say that no other organization in your community has the mission that carries the same responsibility, which is, improving the health status of the population versus the treatment of individuals. It is impossible to provide population based services without engaging in the three core functions.

The reason that you get involved in performing the core functions is to provide you the capacity to have the foundation for population based services. It's also your key to your role in prevention. No other agency primarily addresses the true causes of morbidity and mortality through preventive services as local health departments do. You have a role in anticipation. Local health departments anticipate and prevent disease and injury. They anticipate in a pro-active manner so that they can mobilize efforts to promote health.

How would the role of your local health department change, with the upcoming healthcare reform, and the subsequent out-fall from it? I would suggest that there are many things that you will be doing differently, some things you will stop doing, but many things will require a strengthening of your skills to do better, more, and step forward and take leadership in. The first thing that you need to do is **do not give into the urge to fill the market gap as we have in the last 80 to 120 years.**

....We have looked at our community.
....We have assessed the need.
....We see a need and we go fill it.

No longer is that an automatic role according to the three core functions. Remember, under the assurance phase you were encouraged to purchase and then finally, to provide services. Your second role is in the development of new partners. Partners that you have not come to the table with before - you have not even thought of inviting over to your office before. Many of these people are your previous competitors.

Your third role would be as a community leader. This role will take many forms. You will become a convener, you will become a catalyst, you will become a facilitator, a collaborator and a partner. Most importantly, you will become a role model. You will teach people how to do all these things. You will demonstrate and inform the community on approaches that lead to new problem solving, community ownership, and community resource generation. There are a variety of ways that we do that. Our agencies are at different stages of development as we move into this. All of us have skill building to do.

How will the roles of health departments change in the future?

You will be moving away from the delivery of personal health services. If you are not moving away from personal health services, the balance between personal health services/assurance and the policy development and the assessment functions will change. There will be greater emphasis on the latter two. Your next challenge is to break the mental models. If any of you are fans of Peter Senge and his book, The Fifth Discipline, you are familiar with this term. It's getting rid of, the same as, "we've always done it this way," the sacred cows, the logs in the middle of the stream. That kind of thinking, the illusions or perceptions, are what keep people stuck.

In the work by David Osborne and Ted Gabbler, Reinventing Government, I have found that there are some philosophical descriptions in that document that clearly support moving public health away from personal health services and into the three core functions. These authors frequently use the terms, **Steering and rowing** activities. In their first chapter called "Catalytic Government" they quote a definition by E.S. Savas. He defines government and I quote, **"the word government is from a greek word, which means to steer**. The job of government is to steer, not to row the boat. Delivering services is rowing and government is not always very good at rowing." Further into that chapter, the authors talk about governments changing their roles, saying that "city government will have to make adjustments, and in some ways redefine their traditional roles. I believe the city, in the future will more often define it's role as a catalyst and a facilitator. The city will more often find itself in the role of defining problems and then assembling resources with others, to be used in solving those problems."

City government will have to become more willing to interweave scarce public and private resources, in order to achieve it's communities goals. If you think about the core functions they clearly are steering. They are leadership, they are facilitating, they are moving people forward, they are leveraging resources. Rowing is what we have done and we have done well. But if we continue to row we are not fulfilling the challenge of the core functions.

In 1991, Hillsborough County, Florida, Public Health Unit Florida analyzed what they were doing around the three core functions, and I dare say that they probably look very comparable to what the rest of us would look like at that same point in time, if we assess where we are placing our resources in addressing these core functions. On a scale of 1 to 100, the percent of manpower hours Hillsborough County put into assessment was 9.1%. Policy development was 2.1% and assurance was 88.7%. They were definitely rowing. We all struggle to address the needs of our customers. We are many times bound by the barriers that are put up by our funders, or the limitations that we have put on ourselves, in designing our programs.

We must move from categorical program-driven service activities to customer driven de-categorized funding. Another action that health departments are going to have to take is to reorganize. To put the three core functions into many existing organizational charts makes absolutely no sense. If you are going to organize to carry out these core functions, the required skills may not now be placed appropriately. You will most likely need to retrain staff to carry out the core functions.

The other thing that you are going to have to do in terms of breaking the mental models is you really need to reinvent yourself. You are going to have to start thinking of ways in your bureaucracy, the system you work in, to strive towards removing many of the unnecessary controls. We get caught up in trying to please the unnecessary controls, and we waste a lot of our resources, whether they be in steering or rowing functions. You need to promote competition within your organization. Staff have tended to not assume responsibilities for some of the things that are critical to making government run smoother. There are many ways that you can promote competition. The hours people work, the services that you offer, the way you collect fees, the way you promote your product.

Another reinventing activity is to focus on the outcome. Empower your customers. Make them part of your outcome process. We have for too long looked at process and frankly, your largest funder - the people, don't care what you are doing. They care what their dollar is buying. As we do now, but with even greater emphasis, we shift our resources to prevention. If, in fact, we move towards a healthcare reform that provides access through a card or some kind of payment source, in that people will be able to get tertiary care and specialty health services other places, why would we continue to offer that? Why would we not try and beef up the other end of the health-illness continuum?

Another habit that you must break away from is trying to do it all yourselves. You must focus on catalyzing all sectors of the community to solve problems. You should not, nor can you, own all these problems in isolation. The days of government fixing and government taking care of it are no longer, because people are not willing to finance what it takes in order for us to do that.

So again, the roles that I have spoken about earlier, about the convener and the facilitator and the partner, are critical in order for you to reinvent yourself. I would also challenge, that you begin earning money rather than spending it. And lastly, in your new reinventing mode, you need to shift the focus and this is not just a word game. Along with this goes a change in attitude, goes a change in performance, goes a change in mission, goes a change in organization. Look what's happened after July, 1993 in Illinois'local health departments. Very different, very much in keeping with the three core functions and frankly, very much in a unique market nitch.

.... How will you survive?
.... What are the signs of change?
.... How will you know you've made a difference?

First of all you must have leadership. Each of you are in a leadership role in your health department. Leadership does not have to come from the top down! It can come from anywhere in an organization and move in any direction. I would highly encourage you to assume your role. The last four years CityMatCH has been putting on these conferences we have all learned together wonderful skills as to how to become leaders. Your leadership will emanate up as well as emanate down.

Second, there's got to be an attitude change! We are not doing business as usual!

Third, you have to replace bureaucratic thinking, with entrepreneurial thinking.

Fourth, you must move from parochialism to embracing/encompassing strategies.

Fifth, you're quick, you are responsive, you are customer conscious. You are no longer slow, doggy, or non-responsive.

A final thought. In this fast paced reform environment, local health departments need to prepare to be pro-active and develop their infrastructures to carry out the three core public health functions. We are held accountable by our public with different standards than the private sector. Our public pays for our slowness, lack of vision, lack of responsiveness. On the other hand the private sector has been allowed to fail it's way to success for centuries.

The reason I believe so strongly in rationally-based crime prevention policies is because they offer so much more hope than our current policy path. On the one hand, if this country follows its current trends, by the year 2053 we will have over half of our population in prison, without any corresponding increase in safety. That, of course, is unaffordable and it's terrible public policy. On the other hand, there is plenty of documentation supporting the proposition that crime is not destiny, that criminals are not born, they are made. Our country is very effective at creating criminals. Let us become effective at reversing our course and creating more productive citizens.

School-Based Clinics and Local Health Departments

Monday
September 19, 1994

Paul Melinkovich, MD
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The following material is from the slide presentation by Dr. Melinkovich on "The Denver Experience."

Original Staffing Model

1. Services for non-SBHC students - school staff:
    a. school nurse
    b. school social worker
    c. school psychologist

2. Services for SBHC students - SBHC staff:
    a. nurse practitioner/physician assistant
    b. health clerk
    c. substance abuse counselor
    d. mental health counselor
    e. medical director
    f. others

Lincoln High School: Percent Distribution by SBC Non-Registrants, SBC Non-Using Registrants, and SBC Patients, 1987-88 through 1991-92

1987-88

80%	not registered with SBC
20%	registered with and using SBC

1988-89

65%	not registered with SBC
10%	registered with but not using SBC
25%	registered with and using SBC

1989-90

40%	not registered with SBC
15%	registered with but not using SBC
45%	registered with and using SBC

1990-91

35%	not registered with SBC
20%	registered with but not using SBC
45%	registered with and using SBC

1991-92

25%	not registered with SBC
30%	registered with but not using SBC
45%	registered with and using SBC

Lincoln High School SBC: Percent Distribution of Registrants by Source of Insurance, 1991-92

25%	No Insurance
15%	Medicaid
25%	Other Private Insurance
20%	HMO or PPO
15%	DHH Indigent Care Program

Visits and Provider Type - School Year 1992-93, Total Visits - 7,598

42%	Mid-level Practitioner
23%	Substance Abuse
3%	Violence Prevention
4%	Physician
28%	Mental Health

Visits by Primary Diagnosis - School Year 1992-93, Total Visits (All Sites) - 7,598

14%	Substance Abuse
4%	Chronic Condition
2%	Other Conditions
7%	Reproductive Health/STDs
18%	Acute Illness
3%	Acne/Other skin Condition
11%	Physical Exam
41%	Mental Health

Community Partners

1. University of Colorado Health Sciences Center
   a. School of Medicine - Evaluation
   b. School of Nursing - Education
2. The Children's Hospital
   - Tertiary Care
3. The Denver Department of Social Services
   - Child Welfare
4. The Mental Health Corporation of Denver
   - Mental Health
5. Arapahoe House Substance Treatment Program
   - Substance Treatment
6. The Mayor's Office
   - Political Support
7. The Denver Department of Health & Hospitals
   - Medical/Nursing Care
   - Administration

New Staffing Model School Health Care Team: Multidisciplinary Team

1. School Nurse/Nurse Practitioner
2. Health Technician
3. School Social Worker
4. School Psychologist
5. Consulting Pediatrician
6. Mental Health Worker
7. Substance Abuse Counselor

TB Reemerges in Urban Communities: Implications for MCH

Monday
September 19, 1994

The next three articles are based on the TB experiences in three U.S. cities.

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Background. Orange County's population consists of 64.5% White, 23.4% Hispanic, 9.6% Asian and Pacific Islanders, 1.6% Black, 0.4% Native Americans, and 0.5% Other.

Current issues faced by the community include:
1) Rising HIV/AIDS rate,
2) Increasing rate of immigration from countries where TB is endemic,
3) Increasing rate of homelessness, and
4) Overcrowding in correctional institutions.

What Contributed to the TB Outbreak?

1) Low level of awareness that TB is a major issue;
2) Low level of knowledge in the community about the signs, symptoms, and transmission of TB;
3) Low level of knowledge amongst physicians about the diagnosis, treatment, and reporting of TB; and,
4) Lack of preparedness in our internal TB program.

Lessons learned. First, the community needed to be educated about TB (signs, symptoms, and transmission). Second, physicians needed to be educated and a strong public/private link established. We also realized our own Public Health TB programs need to be strengthened, and that legislation was necessary.

Community education was approached through a TB Communication Plan that took into account the target audience(s), message(s) that needed to be sent, and potential communication barriers.

Efforts to improve physician knowledge and public/private linkages included the use of hospital grand rounds, private physician consultations, hospital discharge planning coordination, presentations at minority physician association conferences, offering TB seminars with CME credit, and by publishing and disseminating articles through local medical and public health journals, bulletins, and newsletters.

Public Health TB programs were strengthened through the development of a TB control plan, implementation of a regular review of Orange County's TB control program (structure, efficiency, knowledge, and procedures), use of enhanced surveillance efforts by hiring a masters level Epidemiologist, and development of updated protocols and procedures, including contact tracing, DOT, and case management. Orange County also sought to enhance coordination with private providers by designating a PHN to act as a liaison, as well as working to establish and nurture contacts with physicians and leaders in ethnic minority communities.

Five major legislative efforts were supported:

1) First, health care professionals are required to report identification of a case or suspected case of TB to the local Health Department within 7 days.
2) A health providers' report will include an individual treatment plan consisting of the name of the physician who has specifically agreed to provide medical care, and other pertinent clinical or laboratory information required by the local Health Officer, such as drug susceptibility results.
3) Physicians must keep written documentation of each patient's adherence to the individual treatment plan, as well as report to the local Health Department a patient who stops treatment.
4) Before a patient with known or suspected TB is discharged from a hospital or transferred to another facility, the Health Officer must receive and approve the individual plan.
5) Finally, health care professionals must examine, or refer to the local Health Officer for examination, all household contacts of TB patients.

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Garland, TX

The Garland Health Department is a suburban Health Department. It is located in the Southwestern U.S. and adjacent to a large city (population one million) that has a tuberculosis rate that ranges from 2 to 2½ times the national rate. Garland has seen an increase in peoples from those countries listed as high risk for TB by the Center for Disease Control.

Twenty-two percent of Garland's 180,635 population is non-white. In 1991 the possibility of imported TB was suspected. A foreign-born adult population was targeted, tuberculosis skin testing those adults when they brought their children to immunization clinics. The children of those foreign-born adults are also TB skin tested at age 4 years and 14 years. The yield of positive reactions is approximately 20%.

The school district and one emergency depaprtment assist in reading the skin tests. Follow-up telephone calls and letters are also utilized. Many patients respond to the letters and return for a repeat skin test. As a result of the screening program the county health department now holds a TB clinic twice a month in Garland.

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New York City Department of Health
New York, NY

In 1990, New York City's population was 7.3 million, according to the U.S. Census. Nearly a quarter of the total, or 1.8 million, were children and youth under twenty years of age. Approximately 32 percent were Latino, 31 percent African-American, 29 percent White, and 7 percent Asian or other category.

Twenty percent of the children and youth between 0-17 years of age in New York City in 1990 were estimated to have no health covereage. In 1992, 1,032,954 of the population 0-12 years of age were enrolled in Medicaid. Another 25,000 children age 0-12 were enrolled in the state sponsored Child Health Plus insurance program by the end of 1993.

The infant mortality rate (IMR) in New York City has steadily declined from 13.2 per 100,000 live births in 1988 to 10.2 in 1992. There is still a significant disparity in IMR between Black and White infants.

A 1991 survey of immunization status of preschoolers found only 38% of the children had complete immunizations by age two. Although New York City has not reached its potential, a variety of approaches aimed at parents and providers could help the Department of Health to achieve 90% immunization in the future.

Tuberculosis cases in New York City decreased 15% in 1993. This was the first significant decrease in 15 years. However, New York City continues to have three times as many cases as any other city in the country and four and half times the national case rate.

The real-time trend in tuberculosis cases indicate that culture confirmed cases have decreased even more dramatically than all cases, as a reflection of improved case confirmation procedures for clinically-confirmed tuberculosis. Cases in females have decreased less than cases in males. Reasons for this are unclear; continued rising HIV sera-prevalence among females is one potential explanation.

Cases by sex and age in New York City indicate that the group with highest case rates are males age 25-54 and females age 25-44. From 1990-1992, cases increased steadily in most age groups. In 1993, most age groups experienced significant declines; persons over 65 were one exception to this trend.

TB cases in children decreased between 1991 and 1992 and stayed relatively constant between 1992 and 1993. However, there was a 30% decrease in culture confirmed cases in children under 15 in 1993. This strongly suggests that cases in children have continued to decline, but that the consistent numbers of verified cases reflect improved case verification procedures for children with negative cultures.

African Americans continue to make up more than half of all TB cases in New York City. From 1985-1992, cases in New York City increased slightly among Asians and Whites and dramatically among Hispanics and African Americans. In 1993, cases decreased most dramatically in African Americans and Hispanics. Cases also decreased among White New Yorkers, but increased slightly among Asians.

Cases in New York City by age, race, and ethnicity indicates that in Whites, Hispanics and African Americans, the peak case rates are in the 35-44 age group. In contrast, Asians over 65 have the highest rates of any Asians. In 1993, for the first time Asians over the age of 65 had a higher case rate than any other race/ethnic group.

Case rates by borough indicated that rates are highest in Manhattan, but that Brooklyn accounted for more than one third of TB cases in New York City. 1993 was the first time since 1978 that Brooklyn had more TB cases than Manhattan.

Foreign born cases in New York City have increased steadily as a proportion of all cases, from 21% in 1990 to 27% in 1993. Cases among the foreign born increased slightly in New York City in 1993.

HIV status of cases by sex, indicates that 36% of males and 23% of females were documented and reported to be HIV seropositive. These figures do not include individuals who are HIV tested, but whose HIV results were not reported to the Department of Health.

Causes of the decrease in tuberculosis are undoubtedly multifactorial. The expansion of directly observed therapy as well as decreased spread in the congregate settings of hospitals, shelters, and jails are undoubtedly leading causes. Between 1984 and 1994, directly observed therapy increased dramatically in New York City. Most directly observed therapy is provided by the City Department of Health.

It is possible to arrive at a rough estimate of savings from the decrease in 1993. If previous trends had continued, there would have been an estimated 1,000 more cases than there actually were. At $25,000 per case, this is $25 million. In addition, directly observed therapy undoubtedly prevented many re-hospitalizations of patients who would have become ill again if they had not been taking their medication.

These are minimum estimates - more hospitalization are likely to have been prevented and the estimates presented here do not include prevention of secondary cases and TB infections.

There are important lessions to be learned from the rapid decrease in cases of TB in New York City, by patients, the health care system and society at large.

The Ten Principles of TB Care

Medical providers and health-care workers must be alert for the possibility of TB and provide appropriate care. The ten principles of TB care are:

1. If a patient has a chronic cough, fevers, weight loss, night sweats...Think TB.
2. Report all suspected or confirmed cases of active TB to the Department of Health within 24 hours of diagnosis. Mandated by law and essential for TB control.
3. Offer HIV counseling and testing. Prophylaxis and treatment are extended for those who are HIV positive.
4. Obtain a careful history, especially to identify contacts and document prior treatment with anti-tuberculosis medication.
5. In New York City, the appropriate anti-TB medications for never-treated cases or suspects are isoniazid, rifampin, pyrazinamide and ethambutol.
6. Ideally, all TB patients should be placed in directly observed therapy (DOT).
7. Every effort should be made to provide "patient friendly" services.
8. Never add a single drug to a failing regimen.
9. Monitor patient progress by taking monthly sputum smears and cultures.
10. Seek expert consultation in the management of the TB patient.

Women's Health: Colposcopy Services

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Tri-County Health Department ensures the public health of about 839,507 people in the 3000 square mile area which surrounds the city and county of Denver, Colorado. The department has 212 employees, 7 office sites and 65 programs in Environmental Health, Personal Health, Education and Vital Statistics.

Beginning with the publication of "Healthy People" in 1979, and through the 1980 "Promoting Health/Preventing Disease" and the 1990 "Year 2000" objectives, cervical cancer in women was recognized as a significant health issue. But no one realized to what extent the problem would develop before the cause was even apparent. The HPV virus which was virtually unheard of a few years earlier, by 1989 had surfaced as the number one cause of all cancers of the lower genital tract, male and female.

The PAP test is usually the first indication of the presence of HPV and to pinpoint its exact location the genital area is scanned with a colposcope, a binocular like magnifying tool. With thousands of women needing this evaluation yearly in the state of Colorado, many of the uninsured were going untreated.

The Colorado Legislature responded in 1989 with a special appropriation of $50,000 to assist with the purchase of equipment, the training of staff, and for the diagnosis and treatment of uninsured women. Using the funds from the Legislature as seed money, Tri-County Health Department purchased, borrowed and bargained for the equipment to set up an in-house colposcopy clinic.

In that first year over 200 colposcopies were performed and every women who needed one had it done. With reimbursement from the legislative fund the following year and a small co-pay from clients of $5 to $25, the program was soon self sufficient. By 1992 there was enough surplus to purchase a new colposcope and a LEEP apparatus.

In 1993 we began to see a decline in the rate of abnormal PAPs, but the incidence of HPV as the cause for abnormality is now nearing 100%. The severity of the disease also shows evidence of increase over the past year. Many more cases of severe dysplasia and carcinoma in-situ are appearing.

The need for this service is not going to go away soon. This is a very worthwhile public health service and one that can easily be started up in any area where the abnormal PAP rate is high. Funding is now available in many states from the Wasman Breast and Cervical Cancer Screening Grant. Once established the program becomes self sufficient and rewarding as the cure rate for cervical dysplasia and early cervical cancer continue to be very high.

CityMatCH Spotlights MCH "Success Stories"

Tuesday
September 20, 1994

Presentation of the annual CityMatCH "Urban MCH SpotLight" recognitions for innovative urban health department MCH initiatives continued to be a popular conference feature in 1994. The three health departments recognized as "SpotLight" finalists were Duval County Public Health Department (Jacksonville, FL), Metropolitan Health Department of Nashville/Davidson County (Nashville, TN), and the Philadelphia Health Department (Philadelphia, PA).

The selection process was based on profiles submitted by invited city and county health departments attending the conference. The profiles were evaluated on four selection criteria:

- innovation
- demonstration of health department leadership
- use of existing resources
- reaching the hard the reach

Representatives from each of the recognized health departments, provided brief overviews of their initatives and how they exemplified the selection criteria. Hats off to the Philadelphia Health Department, who made it possible for four employees with front line responsibility for their highlighted initiative to be present for the recognition ceremony. Here is a brief description of each highlighted initiative; for more details please refer to pages 104, 146, and 164 (respectively) in the "Profiles" section.

Improving EP Services by Networking
Duval County Public Health Department
Jacksonville, FL
CityMatCH Contact: Donald Hagel, MD
(904) 354-3907

Effort to provide comprehensive care coordination and case management of post partum patients. Public health nurses are placed at key hospitals to assure new mothers are counseled, started on an appropriate birth control method, and further assisted in receiving referral services for newborn care and other family health needs.

Metropolitan Nashville Stroke Belt Initiative
Metropolitan Health Department of Nashville/ Davidson County
Nashville, TN
CityMatCH Contact: Betty Thompson, RN
(615) 340-5648

Community-based risk factor reduction initiative designed to reduce stroke in the African American community. The key element of the initiative is the development of working partnerships with African American churches to address health disparities in the African American population. All activities are planned by the churches with support from the Health Department.

School Health Social Work Problems
Philadelphia Health Department
Philadelphia, PA
CityMatCH Contact: Susan Lieberman
(215) 685-6827

Collaboration between the Office of Maternal and Child Health, Philadelphia Department of Public Health, and the School District of Philadelphia. Social worker from the Office of Maternal and Child Health are stationed at the two elementary schools in North Philadelphia, working in partnership with the school nurse to enhance the health and support services available to children from pre-school to grade five.

Closing Remarks

Wednesday
September 21, 1994

Carolyn B. Slack, MS, RN
Chairperson, CityMatCH Board of Directors
Administrator, Family Health Services
Columbus, OH

"*Effective leadership during times of transition.*" I really needed this now. I needed this conference. I needed this time away. I needed to connect to my colleagues from across this country. And, I particularly needed to hear and learn about effective leadership in times of transition.

While preparing for these remarks, I thought about transitions. Like most of you, there are many transitions in my city in the health care environment. Mandated managed care, hospitals downsizing inpatient services and increasing their outpatient, home care and community outreach programs and the list could go on. The more I though about our transitions, I was reminded of transitional labor. When I thought about our responses to transitions, I discovered that these are the very signs and symptoms of transitional labor identified in nursing texts. Some of the non-physical signs/symptoms are the following: feelings of frustration; fear of loss of control; irritability surfaces; and vagueness in communications. In addition, probably what makes these transitional labor signs/symptoms worse for many of us, is the fact that this "pregnancy," for which we are laboring, was most likely mistimed, unplanned or maybe even unwanted.

The work we have ahead of us at home is going to be difficult. Many of us are or will experience changes in how our local public health department is organized and financed. We may see changes in what we do every day. Because of the many pending changes in our health departments, I believe our organization, CityMatCH, takes on an even more pivotal role. As a result of our "re-engineering" we are in a better position to improve our organizational infrastructure so that we can develop our capacity to function more effectively as local leaders for children and families and respond to and develop appropriate policy.

This conference has offered us numerous opportunities to learn how to cope and manage complexity and change. We have worked closely together as a learning community for the last 5 days. It is time for each of us to commit to what we will do at home tomorrow. I am taking three main ideas home with me.

First, the data and program evaluation workshops have reinforced the importance of data analysis and evaluation as major public health products. I have some personal commitments as a result of this:

1. Study time - I need to keep learning and practicing what I learn;

2. Sharing the data - I need to make sure that any data collected by programs is fed back to staff;

3. Data based decision making - I need to assure that data are used to inform not only policy, but program planning and service delivery. This must be a very visible process.

Second, everything we do needs to be framed within the context of core public health functions. I need to "speak" core functions more. We need to help staff, and the public, understand and see core functions in what we do. Each person's job should have tasks and be evaluated as doing or supporting the core functions of assessment, policy development and assurance. I need to make the connections clear and make sure my colleagues are doing the same.

Third, I go home with a renewed commitment to our organization - CityMatCH. CityMatCH is an organization of and for urban health department MCH leaders. Our effectiveness depends on our members articulating the issues, concerns and solutions to one another, based on data, of course, and within the context of core public health functions. It is imperative we communicate with each other.

We are here as empowered persons. Our Health Officers have designated us as the MCH leader within our local health department.

We have spent 5 days learning about effective leadership. We are members of an organization of leaders for leaders. By virtue of our presence and participation in this conference, we are ready to return home as more effective leaders and members of this organization.

Have an effective and productive year. And, please, call me.

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* 1994 SpotLight Recognition Recipients

1994

Profiles of Urban Health Department Initiatives

Reaching Out to Urban MCH Populations

	Women's Health			Perinatal Health						Child Health								Adolescent Health				Other	
	Preconception health promotion	Family planning	Breast/cervical cancer	Prenatal care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention/treatment	Breastfeeding/nutrition/WIC	Immunization	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special health care needs	School-linked/school-based services	School-linked/school-based services	Violence prevention/youth-at-risk	Teen pregnancy	Teen parenting	Communicable diseases: STD, HIV/AIDS, TB, HepB	Other*
Akron, Ohio				♦	♦	♦																	
Albuquerque, New Mexico										♦													
Allentown, Pennsylvania										♦					♦	♦					♦		
Anchorage, Alaska		♦																					
Austin, Texas		♦		♦						♦		♦										♦	
Baltimore, Maryland																			♦				
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Madison, Wisconsin										♦													
Memphis, Tennessee				♦																			3
Mesquite, Texas										♦		♦	♦										

*Key: 1=Neural tube defects; 2=Foster care; 3=Adult education; 4=Job training

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1994

Profiles of Urban Health Department Initiatives

	Improving Access to Care for Urban Children and Families												Strengthening Urban Public Health Systems for MCH									
	Overcoming racial/ethnic/language/cultural barriers	Reducing transportation barriers	Expanding private sector linkages	Clergy and health connections	Housing and health connections	Schools and health connections	One-stop shopping, co-location of services	Using mobile vans, *clinics for outreach*	Other outreach activities	Increasing social support systems	Case management/care coordination	Increasing access to Medicaid	Staff training	Strategic planning for urban MCH	Reshaping financing for urban MCH	Securing urban MCH technical assistance	Managed care initiatives	Building coalitions and partnerships	Building MCH data capacity	Immunization tracking, recall systems	Infant/child death review activities	Other
Akron, Ohio																						
Albuquerque, New Mexico																						
Allentown, Pennsylvania		◆							◆		◆											
Anchorage, Alaska																						
Austin, Texas											◆							◆				
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1994

Profiles of Urban Health Department Initiatives

Reaching Out to Urban MCH Populations

	Women's Health			Perinatal Health						Child Health									Adolescent Health				Other	
	Preconception health promotion	Family planning	Breast/cervical cancer	Prenatal care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention/treatment	Breastfeeding/nutrition/WIC	Immunization	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special health care needs	School-linked/school-based services	School-linked/school-based services	Violence prevention/youth-at-risk	Teen pregnancy	Teen parenting	Communicable diseases: STD, HIV/AIDS, TB, HepB	Other*
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Washington, D.C.																							
Wilmington, Delaware		♦	♦	♦		♦																	

*Key: 1=Neural tube defects; 2=Foster care; 3=Adult education; 4=Job training

1994 Profiles of Urban Health Department Initiatives	Improving Access to Care for Urban Children and Families												Strengthening Urban Public Health Systems for MCH									
	Overcoming racial/ethnic/language/ cultural barriers	Reducing transportation barriers	Expanding private sector linkages	Clergy and health connections	Housing and health connections	Schools and health connections	One-stop shopping, co-location of services	Using mobile vans, clinics for outreach	Other outreach activities	Increasing social support systems	Case management/care coordination	Increasing access to Medicaid	Staff training	Strategic planning for urban MCH	Reshaping financing for urban MCH	Securing urban MCH technical assistance	Managed care initiatives	Building coalitions and partnerships	Building MCH data capacity	Immunization tracking, recall systems	Infant/child death review activities	Other
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Tacoma, Washington		◆	◆			◆												◆				
Tucson, Arizona																						
Washington, D.C.										◆		◆	◆									
Wilmington, Delaware																						

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	City of Akron
CITY/STATE:	Akron, OH
CityMatCH CONTACT:	Beverly Parkman
TELEPHONE:	216/375-2369

CONTACT FOR MORE INFORMATION: Chris Richmond (216/773-6838, FAX: 216/773-0348)

1a. **Initiative Name:** Lifelink-Prenatal Outreach Program

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 04 Prenatal care; 05 Expanding maternity services; 06 Home visiting

2. **Describe the initiative.** Establishment of a "pilot" program of indigenous community health workers in an Akron neighborhood following the Cleveland Metro Health Medical Center model. Cleveland Metro Health studied three different research/service outreach programs and selected the one which resulted in the most significant decrease in infant mortality for continued programming. They saw an average reduction of 26% in infant mortality in targeted neighborhoods over three years. We've chosen to emulate their approach.

   Reduce the proportion of pregnant women in census tracts 5032 and 52034 who do not receive timely prenatal care from 39% to 10% by the Year 2000. (Over the past five years, 80 to 100 births have occurred in these census tracts annually, with 36 to 39 births occurring to women who started prenatal care late.)

   a. In conjunction with the East Akron Community House, hire five one-half time indigenous workers - women who are members of the targeted community. Train these women in the basics of pregnancy and prenatal care, and in effective interaction with clients and medical personnel. Give them the responsibility to find and encourage women to get regular prenatal care, including bonuses for women who start care in the first trimester and who keep at least 80% of their clinic appointments.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Summit County has three health departments and five hospitals that comprise the Summit County Prenatal Task Force. This group, Chaired by C. William Keck, MD, MPH, Director of the City of Akron Department of Public Health, developed the project which is based in a community service agency located in the target area.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, as each committee and subcommittee of the task force meets, agency representatives at all levels work together to implement and improve care for pregnant women.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Systematic Barriers: women do not know how to access the system to care; do not have the proper or necessary documentation for care i.e. proof of pregnancy, information related to system enrollment.

How overcome? The Life Link initiative has been able to access the system for these women, expedite their care by intaking necessary information prior to making appointments working with these moms on a one to one basis and provide time to explain the system and bureaucracy of receiving care the "this is how it is done" Also, the Life Link initiative has been successful in bringing a wraparound services approach w/coordination with hospitals /clinics/Department of Human Services/WIC/etc.

Barrier 2: Socio-demographic barriers: Women who have substance abuse problems. Teens who do not have family support. Women feel it is not necessary especially with repeated births basic ignorance to importance of early care.

How overcome? The Outreach Workers have worked with the women one on one to get them into care and with training they have been able to enroll women w/substance abuse problems into care. This is done by ensuring the women that prenatal care and the substance problem can be treated. With teens, where family mediation is necessary Outreach Staff have referred and brought families back together or teens have sought guardians. Through information and education brought to the community, the importance of prenatal care is instilled.

5. **How is it funded?** City/County/Local government funds; Specify: Summa Health System Akron General Medical Center, Cuyahoga Falls General Hospital, Childrens Hospital Medical.

What is the approximate annual budget for this initiative? $125,000

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date?** Objectives: 1) To enroll 55 women into care by Dec. '94; 2) to work with these moms/children through the childs first birthday; 3) To assist women w/prenatal care plan; 4) to inform/educate community to get women into early care - DATA COLLECTED? MONITORED - It is collected through the intake/enrollment forms and prenatal assessments. It is used to monitor the number of women of clinic visits (goal to have 80% of visits kept by moms), and follow through on immunizations. MAJOR ACCOMPLISHMENTS TO DATE: Since 3-21-94 when the project started, 40 women have been enrolled into care, 39 have maintained on going care. Women with children have been brought current on children's immunizations, Coordination and collaboration of services for nutritional needs, public aid, pregnancy educational child development services & classes have all been initiated due to Life Link.

6b. **Has this initiative been formally evaluated?** At this time, no.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes, It is needed.

Why? To get back to community based public healthcare. The program is in its sixth month and has exceeded our expectations, however we need at least a year of operation to evaluate its effectiveness.

7b. **Has this program been replicated elsewhere?** No, not that we are aware. A public/private partnership has been established.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Bernalillo County Health Department
CITY/STATE: Albuquerque, NM

CityMatCH CONTACT: Sally Kennedy
TELEPHONE: 515/841-4125

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Albuquerque Preschool Immunization Demonstration Project

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization

2. **Describe the initiative.** Albuquerque, NM had low preschool immunization rates. The goal of the demonstration project was to increase the age-appropriate preschool vaccination of children ages 0-24 months by decreasing barriers at the provider, consumer, and systems level.

The 18 Standards for Pediatric Immunization Practices were the bases of the Project's objectives and activities. An intervention and control site were chosen to measure the impact of the interventions. These two areas are geographically adjacent but represent distinct communities within Albuquerque.

The interventions focused on expanded immunization clinics, in-service training to public and private providers, linkage with the WIC program, increased community awareness about the importance of immunizations, and the use of a recall/reminder system. All of these interventions have continued even though the project has ended.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The public health department has increased the accessibility of immunizations and increased private providers' awareness of the immunization rates within Albuquerque.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, New collaborative activities with hospitals, civic organizations, and businesses have developed.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Limited accessibility to immunizations.

How overcome? Immunizations are given 8-5, including lunch time, Monday through Friday. Immunizations are available on a walk-in basis. They are offered in the evening, once weekly, with WIC.

Barrier 2: Parents don't keep track of immunizations needed by their children.

How overcome? Letters are sent to parents of newborns to notify them of when to start immunizations. All children enrolled in the clinic receive reminder letters. Parents are notified of missed immunizations.

5. How is it funded? Other federal funds.

What is the approximate annual budget for this initiative? $500,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? No. Process, impact, and outcome evaluations were completed. These evaluation components relate to the 18 standards for Pediatric immunization practices. The process evaluation monitors the structure of the program and the methods of operation. A pre- and post-intervention survey was completed in the community. It measured knowledge, attitudes, and behavior. The impact evaluation included baseline, quarterly and post intervention assessment audits of clinic vaccination records, observational spot checks of clinics for missed opportunities, and implementation of the standards. The outcome evaluation measured the pre- and post-intervention immunization levels. For the intervention site the baseline immunization was 53.4% and the post-intervention level was 66.0%. Some of the barriers were decreased.

6b. Has this initiative been formally evaluated? In process.

7a. Do you think that this initiative would work if implemented in another urban community?

Why? We were able to implement the most successful interventions in other clinic sites in Albuquerque and other cities in New Mexico. Some of these same interventions could be successfully implemented in other urban communities.

7b. Has this program been replicated elsewhere? Yes

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Allentown Health Bureau
CITY/STATE: Allentown, PA

CityMatCH CONTACT: Joanne Barham, RN, BSN
TELEPHONE: 610/437-7615

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Allentown Health Bureau Maternal and Child Health Program

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization; 15 Lead poisoning; 16 Children with special health care needs
Adolescent Health - 21 Teen parenting
Improving Access to Care - 25 Reducing transportation barriers; 32 Other outreach activities; 34 Case management/care coordination

2. **Describe the initiative.** The Allentown Health Bureau's Maternal and Child Health (MCH) Program believes that services critical to health promotion and disease prevention include age-appropriate screening and immunization, health education, identification of special needs and referral, and facilitating linkages between clients and health care providers. The MCH program consists of the following components:

Child Health and Advocacy: Provides intervention by community health nurses for children at risk due to medical or social needs. A case management approach is utilized for families, which includes home and family assessment, planning, intervention via home visits, health education or referrals, and evaluation.

Immunization Program: Strives to improve immunization levels in the city so that 90% of preschool children are appropriately immunized by age 2 years, according to the year 2000 objectives.

Childhood Lead Poisoning Prevention Program: Continues to increase identification and management of children under 6 years with elevated blood lead levels. This includes education, screening, environmental, and medical management.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The leadership of the health department has been to plan the types of services provided, methods of intervention and evaluation, and communicating to providers, agencies, and the community about our new and unique services.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** It has been enhanced because the Health Bureau is the only agency in the city providing these services. The services are unique because they utilize a case management approach, and services are not limited to families due to third party reimbursement.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Community agencies and health providers becoming aware and utilizing our services. How overcome? Ongoing communication by phone and letters to these providers, reminding them of our services and encouraging them to use the program.	Barrier 2: Financial component of dental program - funds are used very quickly due to severe need of services. How overcome? 1) Charitable work is being done by a group of 8 participating dentists. 2) Assisting clients in enrolling in Blue Chip, Mery, and Medical Assistance which will cover some care.

5. How is it funded? City/County/Local government funds; MCH block grant funds.

What is the approximate annual budget for this initiative? Advocacy/Dental $55,000; Child Health $30,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The MCH program has specific, measurable objectives, which are monitored and evaluated on a quarterly basis. Data is collected via documentation in client charts (each family has a care plan which is evaluated continually during services), home visit logs, and community outreach activity logs. Accomplishments: **Child Health and Advocacy** - 1) 52 home visits completed between 5/6/94 and 7/29/94; 2) 107 children were accessed to and received care by dental providers; 3) 210 children linked with primary care providers since 6/1/94; 4) 10 children accessed to health insurance coverage; and, 5) 4 health education workshops completed in July. **Immunization Program** - 1) Immunization coalition established to develop innovative methods of increasing immunization rates. Coalition consists of health care providers, school, business, and church leaders, and concerned citizens; 2) Celebration of National Infant Immunization Week including a mayoral proclamation, a school poster contest, and media coverage of events; 3) Development of satellite immunization clinics in senior centers; 4) Education materials developed and distributed to health care providers and social service agencies, including those serving the Latino community; and, 5) Mrs. Betty Bumpers and Mrs. Rosalyn Carter of Every Child By Two and Mrs. Ellen Casey, wife of Governor Casey, are to visit in support of the coalition's efforts on September 15, 1994. **Childhood Lead Poisoning Prevention Program** - 1) 50 children are currently in medical and environmental management; 2) The program screens 1,100 children per year; 3) Monitors and educates, on an ongoing basis, children with mild elevations. The program receives referrals averaging 10 new children per month; 4) New bilingual, low-literacy education materials were developed and distributed. Educational programs regarding lead poisoning prevention are provided to day care centers and social service agencies; and 5) Allentown Health Bureau completes full environmental testing vs. a previous outside agency.

6b. Has this initiative been formally evaluated? Yes, on a quarterly basis.

7a. Do you think that this initiative would work if implemented in another urban community? It would work in other urban communities.

Why? Because of the need for the services and education; by using a case management approach and objectives, it is easy to evaluate the program.

7b. Has this program been replicated elsewhere? Not that we know of.

If yes, where?

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1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Municipality of Anchorage, Department of Health & Human Services
CITY/STATE:	Anchorage, AK
CityMatCH CONTACT:	Carole McConnell
TELEPHONE:	907/343-6128

CONTACT FOR MORE INFORMATION: Lynn Hartz, MSN, FNP (907/343-4623)

1a. **Initiative Name:** Colposcopy Project

1b. **Category(ies) that best applies to your initiative:**
Women's Health - 02 Family planning

2. **Describe the initiative.** The colposcopy project was designed and implemented within the framework of a family planning clinic at the Department of Health & Human Services in response to an increasing rate of abnormal pap smears in the family planning population. The goal of the project is to prevent cervical cancer in teenagers and low-income women at-risk through early intervention and treatment. Clients with two consecutive atypical pap smears or one pap smear with cervical intraepithelial neoplasia are referred to the colposcopy clinic if they have no health insurance, fall within state poverty guidelines, or are less than 19 years of age. Colposcopy clinics are held twice a month and staffed by at least two nurse practitioners trained in colposcopy. A clinic held every other month is staffed by physicians who donate their time and sit on the Family Planning Medical Advisory Committee. The physician's clinic is used for consultation by the practitioner for advanced problems. Data are collected on thirty-five variables for each patient and entered into a computerized data base. Patients referred out for care are given an extensive referral packet and a list of physicians who have agreed to see clinic patients for a "consultation visit." The physicians have agreed to see these clients for a preset consultation fee but treatment costs are not discounted. Each client referred to private medical care is followed until treatment is completed or for a minimum of four months.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** A leadership role of the health department already existed in the community. The family planning program was able to plan and design a colposcopy clinic with the sanction of the medical community because the nurse practitioners and family planning staff over time developed a strong collaborative relationship with the local physicians. These nurse practitioners were among the first to be trained in Region X to perform colposcopy and biopsy, thus their leadership for the region was established. A Title X, Family Planning National Priority Project was written and accepted. The first colposcopy clinic was established.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. Locally, collaboration between the public and private health care systems has been enhanced because of the referral system and consultation clinics used by the colposcopy clinic. The health department's family planning program has gained recognition nationally for establishing a colposcopy clinic. This recognition is verified by the fact that all state family planning administrators have requested the manual written by a practitioner that outlines the steps in establishing a colposcopy clinic.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of start-up funds. How overcome? A grant was written and funded by a Title X National Priority Grant and sponsored by USPHS Region X Family Planning.	Barrier 2: Helping patients to bridge the gap between the health department and getting treatment at private physicians' offices. How overcome? The use of "consultation visit." Patients referred out for care are seen by physicians who through previous arranged agreement will see these clients at lower office cost. This visit is a brief, no-exam visit where all paperwork is reviewed and the patient receives recommendations for treatment and cost estimates for treatment options. This consultation visit helps to overcome 2 major barriers for the patient, fear of how much the visit will cost and fear of going to a private medical office and not knowing what will be done to them.

5. How is it funded? Other: Title X, Family Planning National Priority Project.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? In order to fulfill its goal of prevention of cervical cancer, the colposcopy project must fulfill two objectives: 1) provision of high quality colposcopy services; 2) facilitating treatment of any disease found. Thirty-six variables for each patient are collected and entered into a computerized data base. This information is analyzed by Epi Info. The compliance rate of patients referred for treatment is 88%. Sixty-eight (68%) of patients biopsied were diagnosed with dysplasia. Only one patient with severe cervical disease has been lost to follow-up. Studies of comparable populations document compliance rates of 68-86%.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? The colposcopy project model lends itself to use in other communities.

Why? It enhances public and private cooperation and benefits both sectors. Easily duplicated forms, protocols, a standardized data management system, and referral system will make it possible to provide colposcopy services in many different settings.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Travis County Health Department
CITY/STATE:	Austin, TX
CityMatCH CONTACT:	Donna Bacchi, MD, MPH
TELEPHONE:	512/476-0020

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Thurmond Heights Wellness Center

1b. Category(ies) that best applies to your initiative:
Improving Access to Care - 34 Case management/care coordination
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships
Child Health - 12 EPSDT/screenings; 10 Immunization
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, TB, HepB
Women's Health - 02 Family planning
Prenatal Health - 04 Prenatal care

2. **Describe the initiative.** The Thurmond Heights Wellness Center provides preventive health care, case management, health education, and coalition building in an underserved community in North Austin. The Wellness Center team is staffed by one full-time R.N., two full-time community outreach workers, and two full-time VISTA volunteers. The project is managed by a community outreach coordinator with a medical doctor as a medical consultant.

The Wellness Center is located at Thurmond Heights, an Austin Housing Authority (AHA) development. A small office facility is provided by the AHA for health services on an appointment and walk-in basis. The staff provides well child EPSDT screening, immunizations, TB testing, family planning, pregnancy testing, prenatal education, STD screening, counseling and referral to appropriate health and social services providers. The staff hopes to alleviate congestion at emergency treatment centers by having a nurse available to examine minor complaints free of charge. EPSDT screenings and immunizations are offered at two other AHA sites in the area, Northgate and Georgian Manor on one day a week. Thurmond Heights will be one of the sites for the Austin Health and Human Services Targeted Case Management Program for high risk women and children. Coalition building is accomplished through the Thurmond Heights Community Health Advisory Coalition. The Coalition meets on a monthly basis. Members include housing neighborhoods service providers and community members.

The Wellness Center provides education programs to the community through schools, churches, AHA learning centers, and other community groups. Programs are presented by Wellness Center staff as well as volunteers from public health education groups such as the American Cancer Society, schools such as the University of Texas School of Nursing, and community members.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The health department wrote the proposal, hired the staff, monitors implementation of activities, and evaluates project. The health department staff delivers the project services.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes, the Austin-Travis County Citizens Health Care Network has recognized this project as "outstanding."

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Staffing core groups need an administrative associate or health educator.

How overcome? Two VISTA volunteers joined the core ground. They assist with administrative duties. Health education is coordinated with other agencies, but would like to hire a fulltime educator.

Barrier 2: Funding - Length of fund was 18 months. The last 12 months are funded at 50% of original amount.

How overcome? Effective October 1, 1994 the City of Austin general funds will fund the two community workers positions. The department will research for funds to fund the entire project since project is funded thru August 31, 1995.

5. How is it funded? City/County/Local government funds; MCH block grant; Third party reimbursement (Medicaid insurance).

What is the approximate annual budget for this initiative? $90,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, project has measurable process objectives, data is collected via monthly reports, AISD Immunization computer print-out, and a pre- and post-survey of residents, some of the outcome measures cannot be achieved within the time frame of grant. Therefore, activities are aimed towards process and impact.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? Because this type of project is responsive to the needs of the residents user friendly, and delivered at a unique site: manager's office at a public housing development. Staff link clients to services that foster continuity of care, coordination of services maximizes community resources, project involves the community in all program aspects, and it's community-based.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Baltimore City Health Department
CITY/STATE:	Baltimore, MD
CityMatCH CONTACT:	Nira Bonner, MD, MPH
TELEPHONE:	410/396-1834

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Baltimore City Integrated Action Plan for the Prevention of Youth Violence

1b. **Category(ies) that best applies to your initiative:**
Adolescent Health - 19 Violence prevention/youth-at-risk

2. **Describe the initiative.** The Baltimore City Health Department hosted a two-day citywide Summit/Retreat this Spring to address the problems of youth violence and prevention. Participants were invited from the community, the Department of Parks and Recreation, the Johns Hopkins Medical Institutions, and other pertinent agencies and organizations. Three focus groups were established, followed by nominal groups which produced a series of recommendations. These recommendations have been sent to the Mayor for citywide implementation. They call for establishment of new programs by several city and other agencies, with some projects to be jointly managed. The projects include the establishment of Rites of Passage programs, new values clarification school curricula, Family Support Centers, consortia of local community adult and youth leaders, mentoring programs, apprenticeship programs, business "adopt and invest" programs, expanded after-school programs, a program for innovative enforcement of truancy and curfew laws.

An Office of Youth Violence Prevention is being established in the Department's Division of Child, Adolescent, and Family Health. This new office will in turn establish a citywide interagency Council on Youth Violence Prevention comprised of representatives of all city agencies involved in such activities. It is understood that the complex and intractable problems of violence can only be addressed effectively by using an integrated approach which brings to bear the resources of several agencies in a coordinated manner.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The initiative for developing innovative programs in the Baltimore City Government has come chiefly from the Health Department. It has acted as the convener, and the repository of staff support for recent violence prevention activities. It sees its role as principle facilitator rather than exclusive implementor of programs.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** People in other city agencies and in nonprofit health and social service agencies have been looking increasingly to the Health Department for guidance and information about new program initiatives on violence prevention. The Department's central mission to prevent disease, injury, and disability make it a natural focus for such new program development.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Developing a coherent set of recommendations from the many suggestions provided by the three diverse nominal groups.

How overcome? A small workshop met consistently every two weeks over several months to hammer out a draft of the recommendations based on public health principles and practical approaches to implementation.

Barrier 2: Obtaining cooperation from diverse agencies in and out of city government to work jointly on violence prevention projects of common concern.

How overcome? By enlisting the support of the Mayor, it is hoped that all agencies will be encouraged to participate and own the program.

5. How is it funded? Pending.

What is the approximate annual budget for this initiative? $50,000 for a Director of Youth Violence Prevention.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?

- Articulating the vision of public health response to youth violence.
- Convening the first interagency, multi-disciplinary summit/retreat to draft consensus recommendations.
- Creating an infrastructure to carry out an action plan. Specific data elements and the evaluation have not yet been developed.

6b. Has this initiative been formally evaluated? N/A

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? By involving the community and leadership at every level, and by using integrated, preventive approaches.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: City of Berkeley
CITY/STATE: Berkeley, CA

CityMatCH CONTACT: Karen Furst
TELEPHONE: 510/644-7744

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Berkeley High School Center

1b. Category(ies) that best apply to your initiative:
Women's Health - 02 Family planning
Adolescent Health - 18 School-linked/school-based services; 20 Teen pregnancy; 21 Teen parenting
Prenatal Health - 06 Home visiting

2. **Describe the initiative.** The Berkeley High School Health Center (BHSHC) is administered by the City of Berkeley Department of Health and Human Services, in partnership with the Berkeley Unified School District. The Health Center is located on the campus of Berkeley High School. The services provided at the Health Center include medical, mental health, health education, and social services. The aim is to provide comprehensive services, which are easily accessible to the students, and well coordinated. Reproductive health services ar a good example of this approach. To address the multifaceted aspects of this issue, services are provided in prevention, education, medical diagnosis and treatment, and psychosocial support.

The Peer Health Education Program focuses in empowering youth with decision skills and positive personal responsibility attitudes. The Peer Educators are trained to educate other students in the high school and in the junior high schools about sexually transmitted diseases, teen pregnancy, and family planning. They also provide information about the services available at the BHSHC. Hearing about the Health Center from their peers helps students be more comfortable to come in for services.

The Expanded Teen Counseling Program provides one-on-one counseling on pregnancy prevention and STD/AIDS prevention. Students receive guidance in choosing a contraceptive method, and over the counter contraceptives are provided for students requesting prescription contraceptives, or screening on-site. Per California law, students receive sensitive services without the need of parental consent. Also available are confidential HIV testing and counseling, and pregnancy testing and counseling. Pregnant teens are referred to the Public Health Nurse for case management, prenatal care follow up, and referrals as needed.

All students using the Health Center are given a psychosocial screening. So students there for other services, such as general primary care, who are at risk for STD or pregnancy would be identified and referred for appropriate counseling, and family planning services if desired. Mental health services are available for students who are identified as needing assistance dealing with issues around sexuality, or relationships.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The City's MCH Director oversees the BHSHC and provides medical direction for the clinic; the City's Department of Health and Human Services funds the Health Center Coordinator and medical staff, provides the Family planning Clinic and counseling services, provides Mental Health Interns, and the Public Health Nurse case manager for the pregnant teens.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? There are many youth initiatives in Berkeley, and the BHSHC has helped the City take a lead in having adolescent health included as an important issue to be addressed.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Funding How overcome? The BHSHC Community Advisory Board petitioned the Berkeley City council for extra funds; the BHSHC Coordinator writes numerous grant applications.	Barrier 2: Coordination among the various programs. How overcome? The BHSHC Coordinator meets regularly with all of the programs and staff to work out problems and coordinate services.

5. How is it funded? City/County/Local government funds; General state funds; Private source(s): California Wellness Foundation.

What is the approximate annual budget for this initiative? $530,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? Data is collected at the time of service delivery and is computerized for ease of evaluation; about 230 students were seen for family planning clinic and counseling services last year.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community?

Why? Being able to offer confidential Family Planning services to adolescents without parental consent would be very difficult in many communities.

7b. Has this program been replicated elsewhere?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Jefferson County Department of Health
CITY/STATE:	Birmingham, AL
CityMatCH CONTACT:	Tracy Hudgins
TELEPHONE:	205/930-1560

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Immunization Delinquent Children Tracking System

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization
Improving Access to Care - 32 Other outreach activities
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships; 43 Immunization tracking, recall systems

2. **Describe the initiative.** An on-line computerized immunization data base system was developed by the Jefferson County Department of Health in 1988. Since its inception, the immunization system has evolved into an electronic tracking system for immunization delinquent children in addition to providing an up-to-date immunization history on each child seen through the Department's seven health centers and nine Healthy Start sites. Immunization information sharing has now expanded to The Children's Hospital through computer linkage with the Department's data base. The Children's Hospital provides specialty services, emergency and some acute care services for children served by the Jefferson County Department of Health and access to immunization history will facilitate care and decrease missed opportunities for immunization.

Utilizing the immunization history data base, an electronic tracking system was developed which targets children 2 years of age and less who are delinquent for at least 1 immunization. DTP, OPV, HIB & MMR status is evaluated, Hepatitis B has not been included in determining delinquent status at this time. Immunization Delinquent Children (IDC) forms used in tracking and documentation of follow-up and patient specific notification mailers are electronically printed for all delinquent children in the target group. Once delinquent status is verified, patient mailers requesting the parent to bring the child in for needed immunizations is sent. Telephone follow-up is routine and if indicated, a home visit is scheduled for patients who do not come into sites for immunization.

Coordination of immunization data input has been developed between health center primary care providers, WIC and Healthy Start staff to improve the data base, decrease missed opportunities for immunization and increase referrals for immunization.

The Jefferson County Department of Health routinely provides approximately 110,000 child health visits per year. A February 1994 CDC random audit of methods used to increase vaccine coverage and evaluate current status in achieving a 90% immunization level for children less than 2 years of age by 1996 revealed a 94% compliance level of Department patients in this age group. Retrospective data from a random sample from 1988 revealed an immunization completion rate of 60%. We feel that outreach activities, extramural clinics, focus on missed opportunities and use of the IDC Tracking System can be credited with the excellent immunization compliance rates of children served through the Jefferson County Department of Health.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Understanding that immunization is a fundamental prevention service that can markedly affect morbidity in the community, the Jefferson County Department of Health initiated the computerized system to improve tracking of immunization delinquent children and to develop a data base for immunizations. A computerized system was deemed necessary due to the large numbers of children in Jefferson County who rely upon JCDH for immunizations and the fact that these children access multiple health care sites within the county.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** JCDH has been recognized for its efforts in achieving 90% immunization compliance by 1996 by the CDC. Development of an immunization data sharing process with The Children's Hospital has enhanced cooperation between our two agencies and sets a precedent for future enhancement of the data base through other providers.

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4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Ensuring the correct data input and correct status reporting into the system.

How overcome? Training of all staff involved to include physician, nurses, clerical, WIC and data entry personnel was identified as the first step in establishing and maintaining a creditable data base. As the data base is dependent upon accurate documentation by medical staff of vaccines given at time of visit, accurate data entry of the vaccines given as well as accurate updating of past immunization history, staff cooperation and understanding of the system was essential to maintaining an accurate data base. Restructuring of the WIC on-line screen to allow for ease in identifying ICD has helped in increased history data input by WIC as well as increasing immunization referrals. Ongoing training programs and monitoring of the data for accuracy are assisting in maintaining the integrity of the system.

Barrier 2: Allotting time and staff to do adequate IDC follow-up. Due to number of children seen and the transient nature of the population, having staff available to track and counsel patients regarding the importance of immunizations was difficult at the health center level.

How overcome? Education of all staff regarding the importance of immunization and emphasis on decreasing missed opportunities has been essential. In addition, physician and nursing staff education regarding true contraindications has helped by decreasing missed opportunities. Public Health representatives located at each health center have been assigned to assist with IDC follow-up. Assistance from Healthy Start outreach workers and Disease Control personnel for tracking and education has been helpful. Incorporation of WIC into obtaining history and implementing a referral process has helped to update the data base and decrease missed opportunities. Disease Control Bureau operates Tot Shot Clinics at Healthy Start sites which increases opportunity for immunizations. Immunization data from Healthy Start sites is entered into the data base. This coordinated multidisciplinary effort has decreased the number of children identified as truly delinquent as well as enhanced the Department's tracking ability.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The objective is to maintain a minimum of 90% immunization compliance rate for children followed by the Jefferson County Department of Health. Information regarding compliance rates is obtained through random audits and review of the IDC data. To date, the Department has achieved 94% immunization compliance rates with children 2 years of age and under and 97% in school age children.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Any health care provider who has on-line computer capability should be able to implement this initiative.

7b. Has this program been replicated elsewhere? Not to our knowledge.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Central District Health Department
CITY/STATE: Boise, ID

CityMatCH CONTACT: Kathy Holley
TELEPHONE: 208/327-8580

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Central Idaho HIV/AIDS One-Stop Clinic

1b. **Category(ies) that best applies to your initiative:**
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, TB, HepB
Improving Access to Care - 30 One-stop shopping, co-location of services; 34 Case management/care coordination

2. **Describe the initiative.** In June, 1994 the Central Idaho HIV/AIDS Consortium in cooperation with the Central District Health Department opened Idaho's first community health clinic for persons living with HIV/AIDS. Clinic services are offered to residents in a 10 county area in central and southwestern Idaho. The area includes Boise, as well as several rural, medically underserved counties. The clinic provides clients and their primary care providers the opportunity to consult with infectious disease specialists experienced in treating HIV. The clinic offers psychosocial support services, nutrition counseling, oral health evaluations, counseling and referral, and case management services to every client.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** In March, 1993, Central District Health Department convened the first ever community-based HIV/AIDS coalition. Sixty-five people representing a broad spectrum of agencies, community-based organizations, health professionals, and people living with HIV/AIDS attended. The Consortium identified three major goals based upon local needs. The priority goal was the establishment of a community "one-stop" health clinic for persons living with HIV/AIDS. CDHD has made a major commitment of staff and resources over the past year to support the Consortium and make that goal a reality.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** No.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Funding of the clinic and consortium. How overcome? A proposal to help supplement the consortium's activities was made in April 1993 to the Rural Health outreach Grant but was not funded. A proposal requesting funds to open a "one-stop shopping" clinic was submitted to the State of Idaho's Department of Health and Welfare, Division of Health in November, 1993. The request was for $40,000 to be funded in part by a portion of Idaho's Ryan White monies ($26,359) along with a supplemental amount of $13,641. The proposal was funded in March, 1994. The Consortium is in the process of looking at funding opportunities with local businesses and private foundations to support all clinic activities.	Barrier 2: How overcome?

5. How is it funded? City/County/Local government funds; Other Federal funds: Ryan White monies.

What is the approximate annual budget for this initiative? $65,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Objectives: Establish a consultative HIV/AIDS clinic in Boise for individuals who are HIV positive or living with AIDS. Provide within the HIV/AIDS clinic a one-stop clinic able to refer individuals for health consultations, social work case management, and personal support services. Provide a clinic that can be used by physicians in rural and urban communities to observe and learn diagnosis and treatment plans for individuals with HIV and symptoms of AIDS.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This initiative provides a model of partnership based upon community sanction. It builds the confidence and capacity of local primary care providers to serve individuals who are HIV+. It transcends turf issues and builds upon professional expertise of a wide variety of disciplines.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Boston Dept of Health & Hospitals
CITY/STATE:	Boston, MA
CityMatCH CONTACT:	Lillian Shirley, RN, MPH
TELEPHONE:	617/534-5515

CONTACT FOR MORE INFORMATION: Ellen Freedman, MPH (617/534-5197)

1a. **Initiative Name:** Window Falls Prevention Program - Kids Can't Fly

1b. **Category(ies) that best apply to your initiative:**
Child Health - 14 Injury (including child abuse)

2. **Describe the initiative.** The Kids Can't Fly initiative was developed by the Department of Health & Hospitals, Childhood Injury Prevention Program in response to a high incidence of children falling out of windows in Boston during the spring and summer of 1993. Eighteen children under age seven fell from windows between the months of June and December; three of these children died. 20-25 children typically fall from windows each year in Boston, but the higher concentration during the summer months focused the city's attention on the issue of child window falls. Kids Can't Fly is a campaign designed to conduct citywide outreach and education to promote awareness about the risk of children falling out of windows. The Window Falls Prevention program was established by the mayor of Boston during the summer of 1994 by city ordinance and is a collaborative effort to provide education, technical assistance and encourage the voluntary installation of window guards by property owners, public housing and homeowners. The program's goals are to: 1) Make safe window guards available by reviewing window guard designs to meet the requirements of the Boston Fire Department and child safety and housing experts; 2) Implement distribution of window guards through a network of stores; 3) Design and distribute educational materials to parents and caregivers; 4) Develop and convey prevention messages to the media; 5) Provide follow-up to children who have fallen from windows; and 6) Establish a surveillance system to track window falls in Boston. Over the past two years Kids Can't Fly has distributed window guards, bilingual literature through a network of neighborhood health centers, family shelters and community agencies. Public and private property managers across the state have received information to distribute to tenants. Through private support a training video was locally filmed and produced on window falls prevention. A public service announcement (PSA) with singer Eric Clapton discussing window falls has been aired two years in a row on local television stations. In addition, television and radio PSA's have been developed by collaborating programs.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Department of Health and Hospitals Childhood Injury Prevention Program (CIPP) identified the need for window falls prevention activities in 1992 through its work with the Pediatric Injury Prevention Task Force at Boston City Hospital. The Health department is recognized as taking the leadership role in this effort when the Massachusetts Office of Public Safety determined that they would not pursue window falls initiatives on the state level. The Dept of Health and Hospitals has played a key role in bringing together agencies and institutions throughout the city to establish a working group to advise and plan strategies and interventions. The Window Falls prevention program has been funded by the city and formally established within the health department. CIPP will oversee policies and procedures developed by the working group. CIPP is responsible for coordinating educational activities and the development of language appropriate materials and acts as the liaison between manufacturers, regulatory agencies and retailers with regard to window guards.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the health department has been enhanced as a result of the name recognition of the Kids Can't Fly Campaign and the linkages made with agencies throughout the city. Public hearing and press conferences have been well covered in the media and supported by the community. The program is accessible to the public via a well publicized phone number to answer questions, provide technical assistance and attend community meetings and events. The health department has been featured by a national news magazine program as an innovative solution and the department's efforts have been presented at the National Conference of Mayors by the Mayor of Boston.

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4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Finding a window guard product that meets requirements for all regulatory agencies and involved parties.

How overcome? The fixed window guards which were used initially in Boston and are used in New York City were considered barrier to exiting a residence in the case of emergency. To gain approval by the Boston Fire Dept we are now examining Operable window guards and are in the process of developing specifications, test protocol and overseeing the manufacturing and distribution of these window guards in Boston.

Barrier 2: Passing a city ordinance to require the installation of window guards by property owners /managers in all residences where children age six and under reside.

How overcome? The major opposition to the legislation was City Inspectional Services who did not want to be responsible for enforcing this regulation and the real estate/rental association who did not want property owners/managers to be required to install window guards. Both parties opposing mandatory installation suggested an aggressive educational campaign coupled with voluntary installation. There is a great deal of participation and support by the Rental Housing Association and voluntary installation is being done by the Boston Housing Authority and some independent property management companies.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? $69,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? Our measurable objectives include the voluntary installation of window guards by 30% in homes with children age six and under in the City of Boston. Data will be collected from the following: 1) Number of public housing units to receive window guards based on figures from Boston Housing Authority and Massachusetts Housing Finance Agency; 2) Number of window guards shipped by manufacturers to Boston retailers; 3) Random survey of property owners with regard to window guards installation; 4) A sample of retailers selling window guards; and 5) Number of window guards donated by charitable organizations, hospitals and city funds. In addition, we are setting up a monitoring mechanism through Boston hospitals to identify window falls admissions and make referrals to the program. The program will follow-up with a home visit, a review of child's medical record and will work with the property owner/manager to install window guards in the building. Our most significant accomplishment is the decrease in the number of window falls by 67% from the same period last year. This decrease can be attributed to increased public awareness and behavior changes such as opening windows from the top down, moving furniture and installing window guards.

6b. Has this initiative been formally evaluated? Yes, Program currently being evaluated.

7a. Do you think that this initiative would work if implemented in another urban community? The Boston initiative was modeled after the New York City Window Falls Prevention program which demonstrated an 86% decline in the number of falls over the fifteen years following the enactment of a law requiring window guards.

Why? It has been shown that window guards are 90% effective in preventing window falls and any urban center which has identified window falls as a public health problem can see this effort duplicated. We also encourage programs to incorporate falls from porches, balconies and other heights where poor quality housing is a contributing to pediatric falls injuries. The work we have done in Boston with discovering an improved window guard design can certainly benefit efforts in other cities needing an operable guard for the purpose of emergency egress. We have been working with national retail chains who could establish partnerships in other cities with products and information from the Boston market.

7b. Has this program been replicated elsewhere? Yes, Chicago, Los Angeles, Philadelphia and New Haven have contacted Kids Can't Fly to implement similar programs or aspects of this program.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Mecklenburg County Health Department
CITY/STATE:	Charlotte, NC
CityMatCH CONTACT:	Polly Baker, RN
TELEPHONE:	704/336-6431

CONTACT FOR MORE INFORMATION: Margaret E. Davis, WIC Nutritionist 740/336-6464

1a. Initiative Name: Breastfeeding Peer Counselor Project

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 09 Breastfeeding/nutrition/WIC
Improving Access to Care - 32 Other outreach activities

2. **Describe the initiative.** Low income, minority and adolescent women who have successfully breastfed their own babies are recruited and trained to serve as breastfeeding counselors for their pregnant and breastfeeding peers. As we enter our third year of operation, we have trained 21 women and currently employ ten of these women, including three with bilingual skills. The peer counselor's goals are to promote breastfeeding and to provide culturally relevant, easily accessible, accurate information and support for women who wish to breastfeed. Our Peer Counselors have become a permanent resource for their communities - serving as role models and being available to provide accurate information and mother-to-mother support. Their work includes: Telephone outreach to new mothers; home and hospital visits; leading bi-monthly support group meetings (Happy Baby Club); presenting breastfeeding classes in hospital and Health Dept. maternity clinics and at monthly childbirth preparation and parenting classes; special outreach project to Teen mothers at TAPS school; participating in continuing education for themselves at conferences, workshops and staff meetings. The Breastfeeding Warm Line - a voice mail link to the community - is another service associated with the Peer Counselors. Their home telephone numbers are recorded on the Warm Line, and is available 365 days a year because of their dedication and willingness to help their peers.

The project has been made possible through a coalition effort involving Health Dept., La Leche League and Carolina Medical Center.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Our Health department initiated the coalition and facilitated planning meetings which led to the establishment of the program. Health Dept./WIC staff wrote the original grants to fund start up. WIC provides a nutritionist to coordinate the program and the H.D. is the "home" base, providing access to clerical support and office equipment.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes. The breastfeeding Peer Counselor Program is a new, cost-effective resource created by and for our community through efforts initiated by the health department. We are now recognized as a leader in our community in the field of breastfeeding promotion, education and support. We are also seen as a resource on matters concerning peer-based services.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Insufficient funds to establish and operate program.

How overcome? Wide, ongoing search for funds from private grant agencies, donations and fund raising events.

Barrier 2: Quality control - Challenge of providing appropriate training and support for counselors to enable them to be a source of accurate information and referral for clients.

How overcome? Collaboration with agencies and organizations with experience and knowledge about breastfeeding and peer support - especially La Leche League and Chicago Breastfeeding Task Force; comprehensive training program; Documentation of all client contacts; Regular monitoring of records; Monthly staff meetings; Mentors for Peer Counselors; Developed referral system of Peer Counselors and H.D./CMC staff; Provide Community Resource list.

5. How is it funded? Other Federal funds: WIC, March of Dimes; Private sources: Healthy Start Foundation for Carolinas, CMC Volunteer; Private donations; Fund raisers-grocery store reimbursement, walkathons; sale of buttons, t-shirts.

What is the approximate annual budget for this initiative? 92/93: $22,000; 93/94: $41,500; 94/95: $30,000.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Initiation rates up 11-2? Objectives: 1) To increase the incidence and duration of breastfeeding among WIC mothers, 2) To contact new breastfeeding mothers within 48 hours of the birth, 3) To provide ongoing follow up to mothers for as long as they choose to breastfeed. A tracking system was developed using log/encounter forms and our computerized patient care management system. Health Department staff, including Peer Counselors, generate an encounter form for each client served. Breastfeeding women and infants are identified by specific codes and information regarding initiation and duration are generated by state WIC office quarterly. A time/log form was devised for bi-monthly report of individual Peer Counselor activity. This data is tabulated and reviewed with Peer Counselors monthly.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? Mothers want what is best for their children. Breastfeeding is unquestionably babies best start. With accessible and culturally relevant information available from an experienced, educated peer, many more women can be assisted to successfully breastfeed their infants. This will improve the health of our nation, reduce costs, strengthen family bonds, and empower women. Everyone benefits.

7b. Has this program been replicated elsewhere? No, not exactly. Only program we know of that successfully combines the efforts of health department, La Leche League and hospital staff.

If yes, where?

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Chicago Department of Health
CITY/STATE: Chicago, IL

City**MatCH** CONTACT: Shirley Fleming
TELEPHONE: 312/747-9815

CONTACT FOR MORE INFORMATION: Ed Mihalek (312/746-5380)

1a. **Initiative Name:** Community Health Immunization Program (CHIP)

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization

2. **Describe the initiative.** Children residing in public housing in Chicago are at greater risk for low vaccine coverage than their counterparts living outside that environment. The CHIP was designed to canvass an entire housing development to identify children behind in their immunizations and immunize them in their apartment.

Community volunteers were recruited to be trained as peer advocates of immunizations. Teams were formed consisting of a nurse, a health educator, and a community volunteer to go door-to-door and immunize delinquent children. When immunizations were not indicated, immunization records were collected and entered into the city's computerized Chicago Housing Authority (CHA) immunization tracking system. This system is capable of forecasting immunizations and generating lists of children in need of their next shots. Reminder letters can also be printed as an additional tool to keep children on track.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The success of the CHIP is directly related to the linkages established with several community agencies serving the residents of the targeted housing development. Volunteers were provided by the Wells Community Initiative, a community organization that works within the neighborhood sponsoring a number of service related activities. The Local Advisory Council (LAC) of the development was instrumental in the planning and implementation of the CHIP. They were also a major factor in helping gain the trust of the residents. The Chicago Department of Health (CDOH) assumed the leadership role in this entire activity. This innovative approach to elevate vaccine coverage in this population was a total community effort. However, the CDOH was viewed by all participants as the lead agency.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The aggressive approach to this significant public health problem demonstrated to the community that the CDOH was committed to listen to community leaders and involve them in finding solutions. This fact alone certainly enhanced the leadership standing of the CDOH in the community.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Security.

How overcome? Communication was established early in the planning stages with the Chicago Police and CHA Police. Each day teams would be assigned to a certain area with a police escort. Itineraries were filed each day and visits were made between 10am and 2pm, times that are considered to be the safest.

Barrier 2: Community Acceptance.

How overcome? Residents and community leaders were involved from the beginning in the planning of CHIP. Their input was invaluable in formulating the final strategy to provide immunization services to the children. CHIP was perceived as a community function rather than a CDOH project.

5. How is it funded? City/County/Local government funds; Other Federal funds.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Through the CHA computerized tracking system, vaccine coverage can be measured. The CDOH is still in the process of establishing a baseline so that the impact of this intervention can eventually be measured.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? This initiative is exportable to another urban community.

Why? With proper planning and community input and support, the CDOH has demonstrated that a door-to-door immunization campaign can be effective.

7b. Has this program been replicated elsewhere?

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: El Paso County Department of Health & Environment
CITY/STATE: Colorado Springs, CO

CityMatCH CONTACT: Betty B. McClain, RN, MSN
TELEPHONE: 719/578-3258

CONTACT FOR MORE INFORMATION: Diana Howell (719/578-3257)

1a. **Initiative Name:** Day Care Consultant Program

1b. **Category(ies) that best applies to your initiative:**
Child Health - 13 Expanded child health services
Improving Access to Care - 26 Expanding private sector linkages

2. **Describe the Initiative.** Children in day care centers are at very high risk for illnesses, accidents and abuse. To address these risks, a day care consultant program was developed. The program provides a public health nurse to consult with a specific child care center as negotiated and contracted. The nurse visits the facility as specified in the contract on a regular basis. She is available to confer on individual or site concerns. The nurse will review records, policies, etc. and coordinates health services. She answers specific questions about communicable disease, growth and development, safety, immunizations and other relevant public health issues. The public health nurse also serves as an advocate for the child-care community.

In addition, two workshops (Child Abuse in the Day-Care Setting and Health Practices in the Day-Care Home) taught by public health nurses were presented to the child-care providers. These classes are now being taught by a private agency with the Health Department in a consultant role.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Nursing Division at the Health Department was the leader in planning and implementing the day care consultant program.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. The Health Department's visibility within the community was increased. There is also a greater awareness within the private sector of the role and expertise of the Health Department.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Staff is reluctant to commit to program area because of need to work with a facility for an extended period of time.

How overcome? Developed a process within the Nursing Division for staff to move in and out of programs when requested.

Barrier 2: Lack of staff to expand program.

How overcome? As new funding is available, the program is expanded as needed.

5. How is it funded? City/County/Local government funds; Contract.

What is the approximate annual budget for this initiative? 10 nurses work in the program for 22 facilities. Each nurse spends approximately 1-1½ hours monthly in this program.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. Data is collected by each public health nurse and entered into a data base by support staff. In addition, the Colorado Department of Public Health and Environment tracks the communicable disease data and the Department of Social Services tracks child abuse data.

The demand for services has been greater than the Health Department can meet. There is increased awareness of identifying child abuse and reporting requirements for suspected child abuse.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? With the growing demand for quality child care and the potential for child care to be a therapeutic component of services to at-risk children, providing a safe and consistent base for protection and prevention is a public health role.

7b. Has this program been replicated elsewhere? Not aware of other Health Departments offering this program.

If yes, where?

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Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Columbus Health Department
CITY/STATE: Columbus, OH

City**MatCH** CONTACT: Carolyn Slack
TELEPHONE: 614/645-7473

CONTACT FOR MORE INFORMATION: Donna Barnhart

1a. Initiative Name: GREAT START, (High Risk Infant Service Delivery Protocol)

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 06 Home visiting; 07 Low birthweight/infant mortality
Child Health - 11 Early intervention/zero to three; 14 Injury (including child abuse)
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. GREAT START, an infant mortality prevention project based in Columbus, Ohio, is a community collaborative effort between the local health department, a major urban delivery hospital and the local child protective services. The protocol begins with uniform risk assessment of all infants born at the delivery hospital, completed by labor and delivery and newborn nursery personnel. Depending on level of risk, assessed infants are referred to a child welfare worker and/or a public health nurse. From the point of referral, coordinated services between the two disciplines are delivered to the infant and his/her family for a minimum of seven months.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The Columbus Health Department was instrumental in the developing of the protocol and the training of all necessary persons. Currently the Health Department's role is to coordinate the home visitation by the public health staff and to ensure communication between agencies.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Collaborative efforts between the agencies have increased our knowledge of the community and strengthened our ability to work collaboratively.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Coordinating services between three agencies with different missions and scope of services.

How overcome? Staff at all levels, from management to field staff, were involved in designing the protocol, creating the evaluation tools, and the day to day implementation. Focus groups consisting of members of all three agencies met throughout all steps of planning and implementation.

Barrier 2: Creating the evaluation component.

How overcome? A team of staff from the three agencies and a Professor of Social Work from Ohio State University developed, tested and are currently using "Goal Attainment Scales" that measure various aspects of an infant's health and a caretaker's parenting abilities. They are being utilized as a pre-test, post-test instrument which should measure the effectiveness of the services delivered to the infants and their families.

5. How is it funded? City/County/Local government; Third party reimbursement (Medicaid, insurance)

What is the approximate annual budget for this initiative? Unkown.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The objectives of GREAT START focus on improving or maintaining an infant's health and a caretaker's parenting abilities. Specific areas include: medical care follow-up, feeding practices, growth and development, day-to-day functioning, caretakers responses to the infant, service linkage and mother's reproductive health. Data is collected utilizing "Goal Attainment Scales" developed specifically for GREAT START. It is still too early in the project to cite any notable accomplishments based on the data collected.

6b. Has this initiative been formally evaluated? Yes, in process

7a. Do you think that this initiative would work if implemented in another urban community? This initiative could be implemented in other communities.

Why? It is a very similar initiative to the Healthy Start program in Hawaii where it has found considerable success. It requires commitment and dedication to reducing rates of infant mortality and child maltreatment in the community.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Hawaii

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	City of Dallas Health Department
CITY/STATE:	Dallas, TX
City**MatCH** CONTACT:	Alice Pita, MD
TELEPHONE:	214/670-8266

CONTACT FOR MORE INFORMATION: Joyce Hopkins, R.N.

1a. **Initiative Name:** Health Education Literacy Partnership (H.E.L.P.)

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 06 Home visiting
Child Health - 10 Immunization; 11 Early intervention/zero to three
Improving Access to Care - 26 Expanding private sector linkages; 33 Increasing social support systems; 34 Case management/care coordination

2. **Describe the initiative.** Being unable to read causes clients not to access health care much like a child fearful of going into a candy store because he/she has no pennies. The Health Education Literacy Partnership (HELP) takes three approaches to promote family literacy as an important aspect of wellness and as a means to improve access to health care for City of Dallas High Risk Case management clients. Community Service Aides (CSAs) encourage and train parents to celebrate their children's developmental milestones and to provide early language and emergent literacy stimulation. They also provide adult literacy and educational guidance to high risk mothers and their families. Multi-generational volunteers read to children in all Child Health Clinics both to enhance cognitive development and to role-model for parents so that they may see book sharing and story telling as a nurturing parenting tool. The third approach is directed to health care professionals to show literacy's role as part of routine health promotion teaching and developmental assessment.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The department exhibited its primary leadership role by insuring that literacy related activities were made available to our clients using existing and enhanced community resources. HELP also pioneered the use of reading and teaching parents appropriate developmental expectations to promote literacy as a way of life and as a means of increasing access to health care.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** By spotlighting reading in a clinic setting, the department focuses on literacy as a way for clients to increase their access to health care and to celebrate the developmental milestones of their children as a natural and nurturing parenting skill of which adult clients themselves may have been deprived.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Demonstrating to health care professionals that literacy is a health care access issue has been a particular challenge because the idea linking the two is a new one.

How overcome? Overcoming the mindset that improving literacy is a low priority remains a continuing struggle. Showing CSAs and other providers how improved client literacy can make their efforts more effective has made them more receptive to placing literacy as a higher priority.

Barrier 2: Encouraging school dropouts and self-perceived poor readers that they can make a difference in their children's lives as an offspring's first teacher is addressed from several directions. The rapidly growing number of these clients speaking only Spanish further has taxed health education efforts.

How overcome? Department nurses and CSAs show clients how to share books that have pictures, magazines, family photo albums with children. They give clients books, and CSAs teach them things to do with their children which enhance cognitive development and emergent literacy. HELP parent education materials are being translated into Spanish and funding to buy children's books in that language is being sought.

5. **How is it funded?** City/County/Local government funding; General state funds; SPRANS funds; Other Federal funds; and Private sources - Donations.

What is the approximate annual budget for this initiative? $202,904.00

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?** Four specific goals are attached. HELP uses a database to monitor trends which include emergency room and hospital admissions, immunization rates, education levels and clinic utilization. Major accomplishments: Waiting room readers in all child health clinics, the volunteer base broadened, Book donations, a grant proposal in progress and tentative continuing education programs for High Risk staff with the Dallas Public Library and the Dallas Public Schools, Three HELP sponsored Survival Skills by the Texas Department of Human Resources, A plan for bringing waiting room readers to Texas WIC clinics, Continued presentations on literacy as a way to better health.

6b. **Has this initiative been formally evaluated?** Don't know.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes.

Why? The concept can be as elaborate as funds allow using home visitors and clinic-based to teach parents how to encourage emergent literacy in their children. It can be accomplished at minimal cost if sufficient volunteer effort is used to read in waiting rooms, show parents by example how to read to children and conduct book drives. Parents can be signed up for library cards in clinics where residency already is verified.

7b. **Has this program been replicated elsewhere?** Yes

If yes, where? Boston City Hospital Reach and Read (ROR) program uses the waiting room reader and book giveaway components of HELP.

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Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Combined Health District of Montgomery County
CITY/STATE: Dayton, OH

City**MatCH** CONTACT: Frederick L. Steed
TELEPHONE: 513/225-4966

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** "Families in Fitness" - Intervention services for overweight adolescents and their families.

1b. **Category(ies) that best applies to your initiative:**
Child Health - 13 Expanded child health services

2. **Describe the initiative.** Cardiovascular disease is the leading cause of death in the United States and in Montgomery County (FY 1992 data). Obesity is an independent risk factor in the occurrence of cardiovascular disease and is being seen with greater prevalence in the child and adolescent population. By intervening with adolescents who are obese, behaviors may be taught or corrected that reverse or decrease the risk for adult cardiovascular disease.

The program offered by the Combined Health District is to teach and implement healthier eating and meal preparation, identification of the risk factors for cardiovascular disease and how to reduce them, and emphasize life-long family fitness through exercise and nutrition. The program is offered for ten weeks with a frequency of 3 sessions per week. The nutrition education segment consists of weekly focus topics presented in an interactive, hands on format with take home assignments to complete. Parents are required to attend these sessions.

Exercise sessions are 30-35 minutes in length and promote sustained aerobic activity that is non-competitive and fun. Parents are encouraged but not required to attend.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Child & Family Health Services and the Adolescent Wellness Centers identify adolescents (9-14 years) that wish to participate in and are in need of overweight intervention. The YMCA provides the facilities for the program. This is an effective partnership because the YMCA is a long standing, well recognized organization concerned with promoting physical, emotional and spiritual well being for youth.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Uncertain at this time.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Overcoming parents' and patients' apathy about getting involved to take action.

How overcome? Questionnaires were administered to find out parents' feelings about their child's weight and what they perceived were barriers to attending a program and making changes.

Barrier 2: Offering the program at a time when the parent would participate with their children.

How overcome? Early evening and weekend schedules to accommodate working families in an easily accessible facility. Providing personal incentives for attendance and program implementation.

5. How is it funded? City/County/Local government funds; and MCH block grant funds.

What is the approximate annual budget for this initiative? $40,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Pre- and post-program questionnaires to determine:

1) Nutritional knowledge gained
2) Cardiovascular risk factors knowledge gained
3) Changes made in attitudes towards healthy lifestyle choices
4) Participation in exercise sessions
5) Monthly assessments of maintenance after the ten-week duration

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This is addressing a national problem and attempts to meet national, i.e., Healthy People 2000 Objectives for nutrition and physical fitness.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Denver Dept of Health & Hospitals
CITY/STATE: Denver, CO

CityMatCH CONTACT: Paul Melinkovich, MD
TELEPHONE: 303/436/7433

CONTACT FOR MORE INFORMATION: Sharon Martin, RN

1a. **Initiative Name:** Denver Metro Infant Immunization Campaign

1b. **Category(ies) that best apply to your initiative:**
Child Health - 10 Immunization

2. **Describe the initiative.** Developed Denver Metropolitan Immunization Outreach Campaign to provide free immunizations to children in the Metro area. The initiative targets communities with high concentrations of low-income children and serves children residing within the jurisdictions of the three major health departments in the Denver Metro area. The participating health departments are Denver, Tri-County (Aurora) and Jefferson (Lakewood). The initiative utilizes staff from all health departments and volunteers to provide immunizations. Assistance with media and promotions is provided by the local Rotary Clubs and the Statewide Immunizations Coalition.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Denver Department of Health and Hospitals provided the leadership to organize the initiative and pull together the other participants.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. Increased recognition of the leadership role of Denver in addressing immunization issues in Denver and the state.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Inability of local health departments to work together. How overcome? 1) Hard work at staff level to address details of initiative. 2) Agreement to evaluate success of initiative after one year.	Barrier 2: How overcome?

5. **How is it funded?** City/County/Local government funds; Other Federal funds.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐
Objectives are primarily related to increasing number of children accessing immunizations. Data on children served, residence, health insurance coverage, immunizations status and reason for using clinics are currently being collected for analysis. Major accomplishment to date is the provision of immunization services to 689 children in the Metro area during the first six months of the year.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?
Yes

Why?

7b. Has this program been replicated elsewhere? No

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Detroit Health Department
CITY/STATE:	Detroit, MI
CityMatCH CONTACT:	Judith Harper West
TELEPHONE:	313/876-4228

CONTACT FOR MORE INFORMATION: Yvonne C. Rush

1a. **Initiative Name:** Detroit Healthy Start Community Development Initiative

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 07 Low birthweight/infant mortality

2. **Describe the initiative.** The goal of the Detroit Healthy Start Project is to reduce infant mortality by 50% in the selected target area within the next five years. The Community Development Initiative is based on three themes:
   - the community is a real partner in fostering change
   - coordination of services begins at the point of the client
   - access to care should be barrier free

   Eleven community organizations have been funded to provide outreach and "inreach" at existing agencies to identify clients who would benefit from the Healthy Start case management approach to prenatal and healthy infant care. This initiative is a crucial link in the development of coalitions of public and private agencies to address the problems of at-risk pregnant women and their families.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Detroit Health Department has coordinated the recruitment and selection process for community groups to participate in this initiative. One staff person monitors CDI performance and arranges support.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Assisting grass-roots community groups in administrative, fiscal and documentation procedures. How overcome? Quarterly inservice training sessions are held for CDI.	Barrier 2: How overcome?

5. How is it funded?

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?
Yes. Data are collected through submission of annual reports submitted by the community groups. The data collection is the major accomplishment to date.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community?
Yes.

Why? Grass-roots community groups are able to locate hard-to-reach pregnant women and get them into care with greater success than are bureaucratic agencies.

7b. Has this program been replicated elsewhere? Unknown.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Durham County Health Department
CITY/STATE:	Durham, NC
CityMatCH CONTACT:	Gayle B. Harris
TELEPHONE:	919/560-7700

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Saturday Maternity Clinic Services

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 04 Prenatal care

2. **Describe the initiative.** The Durham County Health Department is the primary provider of Prenatal care for low income women in our community. Maternity Clinic services and Maternity Care coordination provided by the Health Department are housed at Lincoln Community Health Center, a federally funded community health center. Traditionally, services have been provided Monday-Friday, 8:30 a.m. to 5:00 p.m. each day except Tuesday when clinic hours are extended until 8:00 p.m. In an effort to improve clinic access, the Health Department contracted with the Health Center to provide maternity clinic services, maternity care coordination, childbirth classes, nutrition counseling/WIC services, laboratory services, and transportation on Saturday mornings from 8:30 a.m. to 12:30 p.m. Direct patient services are provided by staff who meet the requirements specified in health department job descriptions. Since the Center has opened for maternity services, a limited number of pediatric services (i.e., immunizations, sick child care, etc) have been added on Saturday mornings at the Center's expense.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Health Department administration introduced this idea to the administrator of the Health Center. With her approval of the idea, the Health Department administration developed the plan, met with the finance officer of the Health Center to determine costs and the County Attorney to develop a comprehensive contract. The Health Center's Personnel Office then hired the necessary staff.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** This initiative is seen as further substantiation of the willingness of the leadership of the health department to work with other agencies to meet the needs of the patient population.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Identifying a mechanism for paying professional staff for working in the clinic since exempt county personnel could not be paid for working overtime. How overcome? The County Attorney assigned to the Health Department designed a contract that would allow the Health Center to employ the appropriate staff for the clinic.	Barrier 2: How overcome?

5. How is it funded? City/County/Local government funds; Third party reimbursement (Medicaid, Insurance)

What is the approximate annual budget for this initiative? $62,500

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? This initiative was introduced to reduce the broken appointment rate by improving clinic access. The number of scheduled appointments and the number of broken appointments are monitored. Patients who do not keep appointments are contacted either by telephone or home visit. If the patient delivered by the time the clinic appointment she is not counted in the number for broken appointments. Prior to the initiation of the Saturday morning clinic sessions, the overall broken appointment rate was 39%. Now it is 21%, with the rate for Saturday morning clinic being 15%.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? This initiative would work in another urban community. Collaboration and coordination would avoid duplication of effort while maximizing resources to meet the needs of our patient population.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: El Paso City-County Health and Environmental District
CITY/STATE: El Paso, Texas

CityMatCH CONTACT: Martha Quiroga, MSN, CNO
TELEPHONE: 915/771-5748

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Schools and Health Connections

1b. **Category(ies) that best applies to your initiative:**
Improving Access to Care - 29 Schools and health connections

2. **Describe the initiative.** During FY 93/94 the El Paso City-County Health & Environmental District was a participant in the collaborative efforts to both plan and develop health care services in connection with schools. By serving as a member of the advisory council to the Kellogg funded project and as a member of the planning committees for two other school districts it was possible to provide information and guidance needed to establish school-based or school-linked health services.

The Health District has been an active member of the Kellogg Advisory Council since its inception. The Council had decided on four sites within the eastern boundaries of the county where health services have always been scarce. The development of the role of the Volunteer Community Health worker is now well known in these sites. This project's main purpose is the education of health professionals in sites which are school-based or school-linked; the multi-disciplinary team approach is also a primary focus at these sites.

Through collaborative efforts the Health District has provided immunizations as a direct service and as a training incentive for new providers at these sites. Child health services and Adult Health Services were also provided. As the Kellogg obtained additional staff many services have been assumed by the project. This comes at a time when the resources of the Health District have been decreased.

The Health District assisted two other independent school districts with the development of "Family Resource Centers." Linkages to the Texas Tech Regional Academic Health Center and the University of Texas at El Paso College of Nursing and Allied Health Sciences were established. Identification of funding through the Texas Department of Health was provided to both projects. In particular providing a constant linkage to the internal resources within the school districts such as the school nurses was imperative. Both systems have begun centers with multi-disciplinary services to include educational services for the community surrounding the sites.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The leadership role of the Health District has involved being supportive, informative, accessible, motivational, and resourceful.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The Health District has been identified as a community developer in the area of health care services for families with limited resources.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Each system has intentions of "doing its own thing." Since each community being serviced has its own individual characteristics, the particulars of how the centers are functioning depend heavily on assessment of needs for that area. Each committee preferred to keep information to itself.	Barrier 2:
How overcome? Respect for each group was maintained. Responses to questions were provided in a timely manner as much as possible. Confidential information from one group was not shared with the other. However, now that a year has passed, the systems are visiting each other and sharing their own details by themselves.	How overcome?

5. How is it funded?

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? No

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?

Why? The main reason that this initiative is presented is to point out that El Paso, a city which has been behind the times in this area of need, is finally joining the rest of the nation in the utilization of school-based health centers! We need to be congratulated in finally accomplishing this effort!!!

7b. Has this program been replicated elsewhere? N/A

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Tri-County Health Department
CITY/STATE: Englewood, CO

CityMatCH CONTACT: Maggie Gier, RNC, MS
TELEPHONE: 303/220-9200

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Mother's First

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 08 Substance abuse prevention/treatment

2. **Describe the initiative.** The Mother's First Program is designed to help prevent fetal damage and to improve family functioning in a targeted population of pregnant women who use alcohol or drugs, or who are experiencing significant psychosocial stress.

The program provides on-site drug, alcohol and psychosocial assessment and counseling; home and clinic visits for support and teaching during the prenatal period and during the infants' first year of life; and referral to appropriate community resources.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The program was conceived and developed by the community health nurses and the prenatal staff of this health department. They had recognized that there were an increasing number of women in the prenatal clinic with these needs which were not being addressed during routine prenatal visits.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Because of this program the health department has been recognized as taking an important role in prevention of drug and alcohol related prenatal and post partum complications including pre-term labor and child neglect and abuse.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: The women identified as most likely to benefit from the program lack insight into the risks to the unborn and infants, and lack social skills to participate in therapeutic groups. How overcome? Most counseling needs to be one-on-one and done in a non-threatening environment like the client's own home or in a park.	Barrier 2: Most clients are low income and don't have access to child care and transportation to keep appointments. How overcome? Collaboration with an addictions facility which had child care and bus tokens or taxi funds was most helpful for these clients.

5. How is it funded? Grant from Childrens Trust Fund and In-Kind.

What is the approximate annual budget for this initiative? $33,518.59

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Measurable objectives were developed by the program coordinator and the Trust Fund representative. Data reports are submitted to the Trust on a quarterly basis and compared to objectives. Six month and annual reports are prepared by the Trust. Regular therapeutic groups held in collaboration with a treatment facility where parenting and substance abuse are discussion topics. Pre-term labor, pre-term birth and low birthweight statistics for this high risk population which are equal or lower than like populations.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? With like staffing and available funding this program would work well in any intercity environment with an at-risk population.

7b. Has this program been replicated elsewhere? No, not to our knowledge.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Lane County Health Department
CITY/STATE:	Eugene, OR
CityMatCH CONTACT:	Jeannette Bobst
TELEPHONE:	503/687-4013

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Lane County Comprehensive Pregnancy Services (LCCPS)

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 04 Prenatal care; 06 Home visiting; 07 Low birthweight/infant mortality
Improving Access to Care - 26 Expanding private sector linkages; 35 Increasing access to Medicaid

2. **Describe the initiative.** Lane County Comprehensive Pregnancy Services (LCCPS) is the joint effort of public, private and non-profit agencies working to provide access to early prenatal care. This effort includes intense, active communication between agencies, and the sharing of some of their specific services in providing prenatal care. The primary goals of the program (initiative) are to provide access to prenatal care for any pregnant woman, regardless of ability to pay; to provide low income women access to prenatal education classes; and to provide newborn follow-up for the women participating in the program. The Public Health Agency acts as the "gate keeper" for clients, using the Case Management model. This management model also provides referral services to other supportive agencies such as Women, Infants and Children (WIC), Oregon State Extension Services and other community social services. The primary agencies are: Lane County Public Health, Sacred Heart General Hospital (SHGH), private obstetrical care providers, and Oregon State Adult and Family Services (Medicaid program). This comprehensive program assures access to affordable, coordinated and high quality prenatal care. Each agency maintains its separate identity, budget and services. If any one agency withdrew from this program, the other agencies would continue to provide their individual services. The uniqueness of this program is the cooperative coordination of diverse agencies. Interagency contracts are not needed. This program was established in 1987 to address the problem of accessing the declining number of OB care providers, the high cost of prenatal care, and the significant number of pregnant women deliverying with inadequate or no prenatal care. This program continues today as it was designed seven years ago.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Public Health worked as co-chair with SHGH in scheduling and conducting the meetings that addressed the affordability and access problems for prenatal care in Lane County. The Lane County Health Officer met independently and individually with the delivering physicians to solicit their interest in working on these problems.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** I would say that our leadership role in the community was enhanced. We are able to bring to the table the county-wide picture of the problem, which many of the urban providers were not aware of. We were able to enlighten the providers in the long term value of Maternal Child Health home visits, as compared to providing vouchers as a short term solution.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Getting OB providers to attend the fact-finding meetings.

How overcome? Several surveys were used in an attempt to find a common day and time for providers and community leaders to meet. County Health Officer met privately with the most senior OB providers in the community to get their input and concerns so that the meetings would have a good chance for success. Breakfast meetings being high on the list, SHGH provided the meeting place and the breakfast.

Barrier 2: Care providers and community leaders lacking knowledge of the full scope of the problem pregnant women were having in accessing affordable prenatal care.

How overcome? SHGH and Public Health gathered statistics and presented them in a graphic manner, so that everyone at the meetings clearly understood the scope of the problem and was willing to actively participate in developing a solution.

5. How is it funded?

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The primary objective was to reduce the number of women delivering with inadequate or no prenatal care. This is monitored from data on the birth certificates. In 1987, the number of women delivering at Sacred Heart Hospital with inadequate care was 255, and by the end of 1991, it was 58.

The second objective was to reduce the "write-off" costs of NICU use. A two year study of 385 mother-infant pairs who received inadequate prenatal care prior to the LCCPS program had a total cost of $966,350 to the hospital. In 1991, for mother-infant pairs receiving adequate prenatal care, the cost to the hospital was $4,230.

6b. Has this initiative been formally evaluated? Yes. An evaluation was done by Dr. Sandy Harvey, University of Oregon.

7a. Do you think that this initiative would work if implemented in another urban community? I think this initiative would work in other urban communities.

Why? Most communities as large or larger than the Eugene/Springfield metro area have all the major agencies of this collaboration program. We have received requests for information on this program from many other Oregon counties, from Billings, Montana and Vancouver, Washington.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Deschutes County, Oregon has implemented a similar LCCPS in conjunction with St. Charles Hospital.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Vanderburgh County Health Department
CITY/STATE: Evansville, IN

CityMatCH CONTACT: Constance E. Block
TELEPHONE: 812/435-5766

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Vanderburgh County Child Health Clinics (MCH Program)

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 06 Home visiting
Improving Access to Care - 34 Case management/care coordination
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** Increased grant for Health Department's 3 full-time Child Health Clinics and expanded cooperative arrangements. Goals: 1) Increase immunization rate: co-located WIC Clinics, assess immunizations and refer to Child Health Clinics. If in arrears or without shot records, issue monthly food vouchers (instead of bi-monthly). 2) Increase Early Periodic Screening and Diagnostic Testing (EPSDT): streamlined process; educated and trained staff. 3) Decrease premature deliveries and low birthweight infants and increase early prenatal care/care coordination: Began free pregnancy tests. Counsel and give help accessing medical care, Medicaid, and other resources. 4) Maintain and enhance collaborative affiliations: a) United Way's First Call for Help to route pregnancy and child health calls to the Health Department's new Resource and Referral line. b) Collaborative arrangements with physicians at 3 hospitals for 24-hour coverage for child Health Clinic clients. Clinics' nurse practitioners have telephone access to hospital physicians during the work day for consultation and referrals. c) Issue clothing coupons for Junior League's new store as incentives to complete immunizations by 15 months and promote breastfeeding. d) Formed a Maternal Child Health Community Board, a network to support comprehensive, community-based health care systems that work to identify and assure family centered, culturally-competent, coordinated services for women of reproductive age, infants, children and adolescents.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Health department staff members led in planning and implementing this activity. It became a collaborative community effort.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. We have made noticeable strides in networking related to maternal and child health in our community. Many needs have been identified. The Health Department has assumed a much more active role regarding community health.

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4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Ponderous nature of bureaucratic government on local and state levels. How overcome? Kept trying! Tackled one point at a time and remained focused on the goal of improving services to pregnant women and to children.	Barrier 2: How overcome?

5. How is it funded? City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? $680,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. Data is collected on computer in the format required by the Indiana Maternal and Child Health and WIC Program. Additional material is tabulated locally.

Statistics are reviewed monthly by the project coordinator and her two supervisors locally. The State Department of Health also reviews material. Final funding approval was received from the State Department of Health in late May, 1994. New staff came on board in July, 1994. No data available yet.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? People are willing to collaborate because the clients involved are mainly lower income and tend to have multiple pressing needs - which tax resources of all care providers. The Health Department provides the free outreach component into homes, the WIC Program and routine preventive child health services on a sliding fee scale basis; other entities offer their specific services in hospitals and offices around the city.

7b. Has this program been replicated elsewhere?

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Genesee County Health Department
CITY/STATE: Flint, MI

CityMatCH CONTACT: Jenifer Murray, PN, MPH
TELEPHONE: 810/785-5263

CONTACT FOR MORE INFORMATION: Carol Roberge (810/785-8530)

1a. **Initiative Name:** Community-Based Early Periodic Screening, Diagnosis & Treatment (EPSDT) Outreach

1b. **Category(ies) that best applies to your initiative:**
Child Health - 12 EPSDT/screenings
Improving Access to Care - 24 Overcoming racial/ethnic/language/cultural barriers
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** Community-Based EPSDT Outreach is the coordinated-collaborative effort between the Genesee County Health Department and the following community-based organizations: Flint and Vicinity Action Community Economic Development (FACED) and Flint Neighborhood Improvement and Preservation Project (FNIPP) in conjunction with the Flint Neighborhood Coalition (FNC). In order to facilitate entry into the health care system, the community-based organizations' outreach staff contact potential clients in the community to encourage participation in the EPSDT screening program by enthusiastically emphasizing the uniqueness and the benefits of receiving an EPSDT comprehensive health screening. Client contacts are made by making personal contacts with eligible clients. Scheduling of appointments and arranging transportation is provided after establishing client eligibility and securing the client's interest in participation. By having community-based people promote the program and encourage participation, the client feels more comfortable in asking questions and enrolling in the program, therefore participation increases.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Department took the initial leadership in developing relationships/partnerships in the EPSDT outreach program. Over time, the process has allowed the Health Department to take less leadership and the community-based organizations to take more leadership.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** By allowing the community to participate in promoting Health Department programs, the credibility of the Health Department has increased. Indirectly, leadership has increased.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: A confidential "listing of eligibles" is the EPSDT outreach workers' crucial informational source of contacting eligible EPSDT Medicaid recipients for screening. Because the outreach workers are not Health Department employees, bureaucratic red tape prevented the outreach workers authorized access to this information.

How overcome? The Genesee County Health Department developed a relationship at the State level Department of Social Services to allow access of outreach workers to the list of eligibles.

Barrier 2: Managed Health Care (HMOs and PSPs) has brought its barriers for the client to receive needed preventive health screenings.

How overcome? Currently, suggestions and discussions are taking place regarding collaboration with some HMOs; such as, letters of agreement to permit the GCHD EPSDT staff perform health screenings on their HMO Medicaid patients. Letters requesting consent for GCHD EPSDT staff to screen PSP patients are being sent to known local PSP physicians. Many PSP physicians have returned written consents for GCHD EPSDT staff to screen their Medicaid PSP patients.

5. How is it funded? General state funds; Third party reimbursement.

What is the approximate annual budget for this initiative? $391,997

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?
Expected number of outreach services for FY 93-94:
- 10,332 appointments to be scheduled (FNC: 7,266; GCHD: 3,056)
- 480 screening appointments to be transported by FACED
- 52.26% client show rate goal

Expected number of clinic services for FY 93-94:
- 6,000 screens

Data is collected by computer by the program coordinator.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community?
Yes, this initiative could work in another urban community.

Why? If the health department takes the time, develops a "community-based" mentality and genuinely wants to work with the community, this could work anywhere. It is real important to let all barriers down, keep an open mind, be willing to set up meetings in community-based settings and respect the differences community-based organizations may have from the health department. This needs to work in other urban areas so that the community is served in a manner that it wants to be served.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: City of Garland Health Department
CITY/STATE: Garland, TX

CityMatCH CONTACT: Grace Rutherford
TELEPHONE: 214/205-3460

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: TB Screening Program

1b. Category(ies) that best applies to your initiative:
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, TB, HepB

2. Describe the initiative. Noting population increases in Hispanic and Asian races combined with poverty and language barriers as well as illegal immigrant status, we decided to screen children and their foreign-born parents who were in the high risk areas of the world specified by CDC (Asia, Africa, Latin America). The screening was provided free and automatically with the child's immunizations. Through this effort, 2 pockets of TB were uncovered and the local county health department (provides all TB for services for public health in the area) now comes to our city twice a month. They were also very supportive in tracking down positive reactors who failed to follow through for treatment.

3a. In planning and implementing this activity, what has been the leadership role of your health department? A the time, everyone else was cutting back on TB screening we were told it was not necessary. No other health department in our area combines immunizations with TB screening at shot clinics.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? It has increased our communication and improved our working relationship with our county health department.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Cost How overcome? A local women's league initially funded the program. When the county saw the results, they were willing to provide the testing again.	Barrier 2: Follow-up How overcome? The amnesty laws and getting a Spanish speaking clerk helped patient cooperation. The school district also helped read student's tests. As active cases were found, the county got more involved in locating and assisting positive reactors to get to clinic for examination and treatment.

5. How is it funded? City/County/Local government funds; Private sources - Junior League.

What is the approximate annual budget for this initiative? $1000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Number and age of clients tested, number and age of clients whose tests are read and the results are reported to the county. About 1/3 receive medication for TB prevention. The county does not report to us # of active cases or # who complete treatment.

Major accomplishments - 1) several active cases found and appropriate actions were taken to stop the spread of disease. 2) now a closer site is available to patients who require TB treatment.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? TB testing is a simple procedure. It does require more time, but much of the explanation can be done by clerical personnel. It is a relatively inexpensive test (< $2/client). The readings of the tests are facilitated if community agencies pull together and the clinic is accessible (time and location).

7b. Has this program been replicated elsewhere? Don't know.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Gary (Prec-Inct Clinic)
CITY/STATE:	Gary, IN
CityMatCH CONTACT:	Sharon Mitchell
TELEPHONE:	291/882-1113

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Co-Location of Community-Based Agencies with Healthy Start Program

1b. **Category(ies) that best apply to your initiative:**
Improving Access to Care - 30 One-stop shopping, co-location of services; 34 Case management/care coordination; 25 Reducing transportation barriers
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** The Health Department's most recent initiative in Maternal-Child Health involved the co-location of community-based agencies with the Healthy Start Program. The MCH clinic and The WIC clinic relocated to join the Healthy Start Program.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Gary Health Department submitted the grant proposal for the planning and implementation of the Healthy Start Program.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the Health Department has been enhanced as a result of this activity. Since the initiative involved four neighboring cities, an inter-local health coalition emerged with the health commissioner of each city. Now, the coalition is at the forefront of all health related issues and grant proposals.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Territorial and different perspectives. How overcome? Keeping focus, open mindness, and city planning committees for individualized needs of the community.	Barrier 2: Territorial Issues: Being a primary care provider on site for prenatal care. How overcome? Because local primary care providers were participating in the referrals for prenatal and pediatric care, a rotating provider schedule was implemented. Also meetings were held to discuss the MCH Clinic services as related to prenatal and well-child care.

5. How is it funded? Other Federal funds.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐ The objectives of the partnership are to create "One Stop Shopping" and decrease the number of barriers to health care. Monthly stats are collected for the number of referrals to and from each agency.

The major accomplishments to date are enhancement and coordination of services. Each agency enhances the service of one another. For example, a pregnant woman in for clinic visit (MCH) can have transportation to the clinic and have tot-drop services (Healthy Start). Plus she is able to have WIC services the same day. This is accomplished thru coordination of services and sharing of records.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This initiative would work if implemented in another urban community since it works well in four neighboring cities. Careful planning and commitment of all parties can enhance various agencies services without duplication of services.

7b. Has this program been replicated elsewhere?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Kent County Health Department
CITY/STATE: Grand Rapids, MI

CityMatCH CONTACT: Wanda Bierman
TELEPHONE: 616/336-3002

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Immunization Action Plan - Outreach

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization
Improving Access to Care - 32 Other outreach activities; 25 Reducing transportation barriers; 26 Expanding private sector linkages
Strengthening Urban Public Health Systems - 43 Immunization tracking, recall systems

2. **Describe the initiative.** This action plan is primarily an outreach activity which has two major components:

1. Newborn - All infants born in Kent County are compiled onto a disc at the Michigan Dept. of Health from the newborn blood screening tests. When infants reach 5 weeks of age a letter and information on immunization schedules and free clinics locations are provided. A refrigerator magnet with the immunization is also included. When the infants reach 3 months and/or 5 months of age our outreach workers call them using the computer software "Contact Plus." If the family has no phone, a letter is sent requesting a call back.

The parent is reminded of the original letter and questioned as to the immunization status of the infant. If immunizations have not been obtained, the reason is documented and solutions are problem-solved. Additional follow-up is provided as necessary.

2. Immunization Software (ImmunSafeWare) is being developed by our dept. which will include a system for follow-up on persons who fall behind schedule. Initially this system will be used in all health dept. clinics in the county. When the system is ready, private providers will be offered the opportunity to join the system. The goal is to have a county-wide system in place. ImmunSafeWare is ready for implementation this Fall.
3. An additional component of our outreach effort includes an Advisory Committee of community representatives from the private and public sector. These are persons vitally interested in promoting immunizations in their own agencies (hospitals, doctor's offices, HMOs, pediatric clinics) or on behalf of clients utilizing their agencies (day care, schools, Head Start). This advisory committee met monthly for the first year and is now meeting quarterly.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Our health department's role has been that of computer software development and outreach to the community. We engaged the state health department in providing the newborn data set on disc for our use and engaged community leaders in serving on the advisory committee. We also sought and received grant monies to assist in this process.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** I believe the community responded very well to this initiative and it is clear that the health department is viewed as having a leadership role in the area of immunizations. There has been much interest in the advisory committee and the outreach activity. Members have been patiently waiting for the software to become available for their eventual use.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Programmer expertise to write and test the software.

How overcome? The original developer of the software changed employment in the middle of development. We were able, however, to contract with him on a part-time basis while the system was being tested. this slowed down the development considerably.

Barrier 2: Staff time to participate in testing and implementing the system.

How overcome? The Immunization Program Supervisor made this initiative a priority and flexed her hours so she would be available to work with the programmer as needed. Key staff were identified who could assist with the testing phase. Part-time staff were encouraged to work extra hours to test the software at times when they were not normally needed to deliver direct clinical services to clients.

5. How is it funded? Other: State grant which includes CDC funding.

What is the approximate annual budget for this initiative? $200,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, we have measurable objectives. The outreach activity to newborns is recorded in a computer software program. Reports are generated each month which include number of persons contacted and a breakout of reasons for not receiving immunizations. We are monitoring the immunization compliance rate of children utilizing the health department's clinics as a measure of outreach success. The major accomplishments include implementation of the Newborn Outreach utilizing Contact Plus software and compilation of data on reasons given for non-compliance; Development of immunization tracking software which is ready for implementation and will eventually be available county wide; Formation of an active Immunization Advisory Committee in the community.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? We are monitored by the state health department.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Kent County Health Department
CITY/STATE:	Grand Rapids, MI
CityMatCH CONTACT:	Wanda Bierman
TELEPHONE:	616/336-3002

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Lead Screening and Tracking Program

1b. **Category(ies) that best applies to your initiative:**
Child Health - 15 Lead poisoning
Improving Access to Care - 34 Case management/care coordination
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** Our health department is screening all children 9 months through 5 years of age who utilize our clinics for EPSDT, WCC or WIC. This amounts to over 12,000 children during the first year of the project. All children screened are entered into a "Tracker" computer system. Referrals are made for secondary screening and once confirmed, the environmental health and nursing home visit divisions are activated. All three divisions in the health department utilize the "Tracker" system to update current status of the child. This computer system is linked to area hospitals as well. The program supervisor attends monthly clinics held at an area hospital which case manages lead burdened children.

In addition to the screening and tracking portions of this project we are also involved in providing community education and medical CME credits. The program supervisor participates on local and state committees aimed at reducing lead poisoning among Michigan children.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Our health department, in collaboration with an area hospital, jointly developed the "Tracker" software system. This system allows multiple providers access to case management information. Our health department has been aggressive in screening children who may be at risk of lead poisoning. The media look to us as experts on lead poisoning in our community.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** I believe it has been enhanced as viewed by the state with whom we have a contract and with the two area hospitals with whom we collaborate. This project has helped to strengthen the coordination within the various divisions of our county health department and improved case management.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Motivation of parents/guardians to get a confirmatory test performed if the capillary screen was high. How overcome? Several contacts are made and if no response, then a referral is made to our community nursing division to make a home visit. We have considered the possibility of obtaining venous samples for screening, however, the pros and cons are still being considered.	Barrier 2: Training our clinic technicians to avoid contamination of the capillary specimen through proper technique. How overcome? The main method is to train our clinic technicians in proper technique. We have obtained a better capillary collection device which has improved this problem. The original collection device provided by the state was difficult for our staff who see a large number of children in a very busy clinic.

5. How is it funded? City/County/Local government funds; State grant - part of federal initiative.

What is the approximate annual budget for this initiative? $100,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, we have specific objectives which are monitored quarterly. Major accomplishments include implementation of new computer software, TRACKER; screening over 12,000 children during the first year; improved community collaboration and case management.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? If a tracking system could be developed. Screening children on the WIC program gives access to an at-risk population. This does increase the time needed to complete blood testing and has an impact on staffing clinics.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Guilford County Health Department
CITY/STATE: Greensboro, NC

CityMatCH CONTACT: Earle H. Yeamans
TELEPHONE: 910/373-3273

CONTACT FOR MORE INFORMATION: Mary M. Sappenfield

1a. Initiative Name: Healthy Years Ahead

1b. Category(ies) that best applies to your initiative:
Child Health - 10 Immunization
Improving Access to Care - 26 Expanding private sector linkages; 32 Other outreach activities
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. The initiative consisted of immunization outreach activities designed to: a) improve community awareness, b) improve access, and c) mobilize the health, business, and civic community around immunizations. A series of 5 consecutive Saturday clinics were held for 3 hours each in non-traditional locations throughout the county to provide immunizations. Advertising (not PSAs) was via radio, television, newspaper, and flyers. Primary sponsors were solicited and included a local radio station, TV station, and local business franchise. Live radio spots were held on site at 4 of the locations. Prizes and incentives were awarded to participants.

Clinics were held at an Urban Ministry Health Center, a Health Department location that previously had not been available on weekends, at local business locations (JiffyLube - automobile lubrication franchise), and at a University-sponsored family awareness activity that drew several thousand people. Children were registered by volunteers from civic groups; Health Department staff reviewed immunization records to determine needs; cellular phones (loaned) were used to call back to the Health Department to check computers or call private MDs as needed; Health Department staff administered vaccines; local pediatricians were on site to provide consultation as needed; volunteers conducted client surveys; prizes were distributed by company reps or volunteers. Success - future community activities are being planned with the same volunteers; this initiative has strengthened the Health Department's role as a community coalition builder.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Health Department acted as a catalyst to bring together local pediatricians, civic and religious groups, and businesses. It provided top level administrative and professional program support through active participation at each monthly meeting and on location during clinics (Child Health Director, Nursing Director, Immunization Nursing Supervisor, Immunization Health Eduator).

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes. Through the partnership effort, local businesses, civic, religious, and medical groups were able to experience first-hand the professional expertise of Health Department staff. These groups have started planning future activities with the Health Department.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Advertising: Needed to create community awareness of immunization issues and announce the clinics.

How overcome? A marketing plan was developed by the radio station and business members of the group. PSAs were ruled out as being a reliable source of advertising during convenient times and with the extent of coverage needed.

Barrier 2: Funding for a marketing campaign.

How overcome? The local radio station sponsor solicited local business to donate funds or other tangibles to the immunization initiative in exchange for radio advertising time. Newspapers provided intense coverage several times each week. TV stations covered the events and aired promotional announcements through the month-long initiative.

5. **How is it funded?** All donated by local business.

What is the approximate annual budget for this initiative? $40,000 for marketing.

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?** Specific, measurable objectives were not established. The primary goals were to increase public awareness of immunization issues and to directly involve many different community groups in a public health issue. Announcements were made on the radio every 15 minutes during prime time each day during the month of the project; newspaper articles appeared in 15 issues; TV spots aired at frequent prime time intervals during the 5 week period. 23 different agencies, groups, or businesses were represented in the planning and implementation.

335 children registered for the clinics; 291 children received a total of 855 doses of vaccine. 71 of the 291 were delinquent by an average of 14 months. Surveys indicated a) Saturdays more convenient for families, b) easier access when located throughout the community, and c) publicity was a key factor in awareness and use of services.

6b. **Has this initiative been formally evaluated?** No.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes.

Why? With a corporate sponsor and if business leaders are involved in all phases of planning and implementation. They have unique experience in marketing and soliciting to reach vast numbers of people and raise sufficient sums of money and donated/loaned products to impelement the project.

7b. **Has this program been replicated elsewhere?** No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Marion County Health Department
CITY/STATE: Indianapolis, IN

CityMatCH CONTACT: Elvin Plank
TELEPHONE: 317/541-2347

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Maternal and Child Health Outreach Program

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 06 Home visiting
Improving Access to Care - 32 Other outreach activities

2. **Describe the initiative.** Indianapolis has provided multidisciplinary care coordination team service in high risk neighborhoods of the City for almost five years. These teams are composed of nurses, social workers, nutritionists, and community health workers. So much energy and time is required to meet the needs of those clients that are referred that almost no time is left to do door-to-door outreach.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Marion County Health Department has provided the entire leadership for this project. We did work closely with the Indianapolis Division of Housing and the Welfare Department in the implementation phases. The Housing Division actually agreed not to raise the rents of the persons we employed for a period of 18 months.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The success of this program in identifying women and children in need has thrust the Health Department into a more visible leadership role with the Welfare Department, the Housing Division as well as City government leaders.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Making it financially feasible for women to work without loosing more benefits than the wages they gained. How overcome? Negotiated an agreement with the Division of Housing so they would not raise rents for 18 months.	Barrier 2: Many of the women in the public housing communities don't want others to know their "business" so they would not let the workers in. How overcome? This was one of the big reasons for having the outreach workers work in apartment complexes outside of their own.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? $100,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? All contacts with persons who are referred for services are documented. The objectives are to have fewer women deliver a baby without prenatal visits per patient. The major accomplishment of this program to date is simply the number of women and children who have been reached and referred.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? I think this approach would work in any urban community.

Why? The success of the program is dependent on employing staff who feel comfortable with making "cold calls" to people they do not know and then being very non-judgmental with the people they come into contact with.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Hinds County Health Department
CITY/STATE:	Jackson, MS
CityMatCH CONTACT:	Don Grillo, MD
TELEPHONE:	601/987-3977

CONTACT FOR MORE INFORMATION: Minta Uzodinma (601/960-7951)

1a. **Initiative Name:** Nurse Sonographer

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 05 Expanding maternity services

2. **Describe the initiative.** In 1983 select nurses and nurse practitioners were recruited and taught sonography procedures. These candidates were recommended by the supervising nurse for the course and had maternity experience. They had demonstrated the ability to assume increased responsibility and were willing to learn the procedure and perform the activity on a regular basis as assigned.

The formal training program that was developed in cooperation and consultation with the Mississippi Board of Nursing includes reading assignments, a lecture by a knowledgeable physician, hands-on demonstration and practice with a patient, and a written test prior to completing 20-30 hours of clinical instruction and supervised practice. After successful, selfpaced completion of the course objectives, the nurse is awarded an agency certificate of recognition as a nurse sonographer. Nurses are taught to perform a basic screening sonogram which meets ACOG standards and includes. 1) number of fetuses, 2) position of fetus, 3) location of placenta, 4) cardiac activity, 5) fetal movement, 6) general body scan of gross malformations of fetal anatomy, 7) amniotic fluid volume, and 8) biometry.

The procedure is often done with portable equipment which the nurse may transport from clinic to clinic. The calculations of specific measurements are done with programmed hand-held computers, if not already part of the particular equipment's menu. The data is recorded on the agency sonogram referral report form. Polaroid pictures or thermal print of the fetal head, fetal femur, presenting part and placenta location are attached to the report and sent to the obstetrical consultant for interpretation and management recommendations.

The nurse sonographer is not asked to identify fetal abnormalities or sex, but a scan for abnormalities is mandatory. Gynecological ultrasounds and targeted ultrasounds must be referred to other sources. In selected cases, the nurse sonographer may do an ultrasound for detection of the gestational sac. Under no circumstances does the nurse sonographer interpret the results. If an urgent or emergency interpretation is required, a consult must be sought from a local qualified radiologist or obstetrician gynecologist.

Nurses who are certified to perform sonograms are required to attend an agency sponsored annual update and continue to perform at least 18 sonograms each year in order to maintain certification to practice in the health department. The obstetrical consultant evaluates the quality of the nurse's work as he receives the referral report and pictures. If the content of data is unsatisfactory, he will counsel the nurse and provide additional clinical teaching as indicated.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Hinds County Health Department has 3 nurse sonographers. Hinds County is the training site and yearly recertification site for nurse sonographers.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Hinds County was one of two county health departments to pilot the implementation of Universal AFP screening. With implementation of Universal AFP, the need for sonograms have increased. Because Hinds County provides 55% of the prenatal care to residents of the county.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Purchasing equipment. How overcome? Central Office helped purchase equipment and paid for equipment maintenance for the first year.	Barrier 2: Staff turnover. How overcome? Because of the many job opportunities for nurses in the Jackson metropolitan area turnover is a problem. The way to help rectify the problem was to have more than one nurse sonographer trained at any given period.

5. How is it funded? Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The three nurse sonographers performed 3,540 sonograms in FY 1994. Data is collected via the Patient Information Management System (PIMS) and the Third Party Billing office. Nurse sonographers are required to be recertified yearly and this information is kept in the nurse's personnel file.

6b. Has this initiative been formally evaluated? Not applicable.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? It is very cost effective and helps to assure early access for a needed service. It does not require hiring additional staff. It is another source of income for the health department.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Statewide - almost every Public Health District has at least one nurse sonographer.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Duval County Public Health Department
CITY/STATE: Jacksonville, FL

CityMatCH CONTACT: Donald Hagel, MD
TELEPHONE: 904/354-3907

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Improving EP Services by Networking

1b. **Category(ies) that best applies to your initiative:**
Women's Health - 02 Family Planning
Perinatal Health - 09 Breastfeeding/nutrition/WIC
Improving Access to Care - 26 Expanding private sector linkages
Strengthening Urban Public Health Services - 41 Building coalitions and partnerships

2. **Describe the initiative.** In response to the need of comprehensive care coordination and case management of post partum patients, the Duval County Public Health Unit initiated an intensive effort to visit, counsel and start every new mother on a birth control method prior to leaving the hospital. The plan was first implemented in November 1993 at the University Medical Center where the majority of public health patients were delivered. Two public health nurses were placed at the hospital and now see approximately 250 patients per month. Each mother is counseled, started on an appropriate form of birth control and is further assisted in receiving referral services for newborn care and other family health needs. A magnetic wipe-off memo board listing telephone numbers for WIC, Healthy Start, Parenting Classes and Clinic Information and allowing a space to write in appointments and other numbers is also given to the patient as they are counseled on referral sources.

As patients usually seen in the public health maternity clinics moved into the private sector due to new Medicaid managed care programs, the MCH staff realized the need to initiate a family planning outreach program at other city hospitals. Review of records indicated the patients eventually did come to public health clinics for family planning, or in many cases for pregnancy tests, and were in need of public health services. Therefore, the public health unit expanded the visitation program to the hospital with the highest number of Medicaid deliveries. An ARNP is stationed at the hospital and provides the counseling, a start-up birth control method and provides linkage with other sources of assistance for the newborn and family members.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Duval County Public Health Unit assumed the leadership role in this initiative. In the planning phase, the Director of Women's Health Services obtained administrative approval and then contacted all providers and agencies involved to design a plan. The effort was implemented, after review by all parties by the public health unit in cooperation with the two hospitals involved.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. As the health care systems were changing rapidly, private providers and other public providers became acutely aware of the need for expanded care for the new mother, especially those on Medicaid or with limited socio-economic resources. It became evident that a public health approach to care would be an assistance to both the family and the medical provider.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Funding source for salaries, office space and supplies.

How overcome? Lengthy negotiations with fiscal, legal, and medical providers resulted in cooperative agreements for payment for salaries and supporting resources. All involved realized the social and economic benefits of the program.

Barrier 2: Short length of hospital stay for maternity patients and weekend and holiday coverage.

How overcome? A specific process for receiving the patient names from the delivery room staff was developed by the family planning staff at each site. Family planning staff then makes four rounds per day to contact the patients. At this time, weekend coverage is not available, however, with four rounds per day, few patients are missed if deliveries occur on Sundays.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? Annual budget under development with new initiative. Salaries account for the majority of the costs.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Measurable objectives: The first process objective was to develop and implement the plan and measure the number of post partum patients placed on birth control. As the program develops, the long term measurement will affect the indicators set for teenage pregnancy and numbers of unplanned pregnancies. Major accomplishments to date include: Expansion to second site, increased compliance rates for post partum visits, increased compliance with birth control method, and a gross decrease in pregnancy rate for public health assigned patients.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes, if careful planning precedes implementation.

Why? As health care reform continues to evolve the comprehensive needs of the maternity/post partum patient will need to be shared by the private sector and the public health community.

7b. Has this program been replicated elsewhere? No.

If yes, where?

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Wyandotte County Health Department
CITY/STATE:	Kansas City, KS
CityMatCH CONTACT:	Margaret Daly, ARNP
TELEPHONE:	913/573-6714

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: High Risk Prenatal and Preterm Labor Prevention Program

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal care; 07 Low birthweight/infant mortality

2. Describe the initiative. Residents of Wyandotte County are at high risk for delivering infants prematurely and/or low birth weight due to the prevalence of many risk factors. The goals of the Maternal and Infant Program (M&I) are to: improve pregnancy outcomes; and, reduce the risk and incidence of low birthweight infants, maternal and infant morbidity and mortality, and child abuse. Local projects facilitate access to prenatal care, promote early entry into care, and compliance with prenatal care for adolescents and other high risk mothers and health care for their infants.

The program features risk identification of all prenatal patients using a multi-disciplinary approach and providing unique services as well as traditional medical services. Three unique features of the high risk prenatal program initiative: 1) identifying women at risk for preterm labor and delivery and working in a concentrated way with these women; 2) providing ancillary support services, such as transportation, social work and nutrition counseling, and home visiting to high risk prenatal patients of PRIVATE obstetricians in the community; and 3) staff includes a substance abuse counselor on site to work specifically with pregnant women and their families.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The program was initiated because of the concern of continuous poor outcomes in Wyandotte County despite a comprehensive prenatal program at the health department available to all residents. The OB consultant who started the program in 1968 and the prenatal coordinator sought out reasons and ways to improve birth outcomes in the community. The program was requested and presented over the Metropolitan area and throughout the State of Kansas.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? The leadership has been enhanced by better collaboration within the community and by the awards and recognition received.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: The need to maintain commitment and cooperation of multiple staff that need to be involved, i.e: hospital nurses, ER staff, clinical staff.	Barrier 2: Perinatal drug abuse.
How overcome? 1) Continuous staff education needs to be done. 2) Frequent feedback of the outcome - good and poor. 3) Administrative support from each institution involved. 4) Staff turnover.	How overcome? We have not found a solution to such an enormous problem. Outreach to welcome women in for care; non-judgmental attitudes; lack of threat of penalty; risk assessment; education; counseling; referral for follow-up; supportive services.

5. How is it funded? City/County/Local government funds; MCH block grant funds; Private sources: March of Dimes; Third Party Reimbursement; Other: patient fees.

What is the approximate annual budget for this initiative? $500,000 plus.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The specific measurable objectives have been the preterm delivery rate. The data is collected by monitoring weeks of gestation at delivery. Review of all questionable PTD and all LBW records. The accomplishments have been that when the program is in full support, the PTD and LBW rates can be decreased. When it is not (ie: 1993) the rates will increase.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? It is felt the program can work anywhere when it is supported by the community. For the program to work, it takes all prenatal staff, in-patient and out-patient nurses, physicians, administration, support staff, and especially the patient and her family.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Kansas City Health Department
CITY/STATE: Kansas City, MO

CityMatCH CONTACT: Sid Bates
TELEPHONE: 816/474-8140

CONTACT FOR MORE INFORMATION: Cynthia Davis (816/474-8140)

1a. **Initiative Name:** Employee Development Seminars, WIC Services

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 09 Breastfeeding/nutrition/WIC

2. **Describe the initiative.** The Kansas City Health Department's WIC Program experienced a 40% increase in participant caseload in the last five years, with corresponding staff expansion. At the same time the program transitioned from a manual service system to an electronic mainframe base, creating increased knowledge requirements.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Realizing the need for a comprehensive training effort, the WIC program requested funding from the State Health Department for consultant work relating to actual seminar development. Funding was provided with the stipulation that selected State staff also receive that training and the development modules be made available to other WIC programs state-wide. Pilot seminars were conducted at the health department with WIC program then expanded to agency sub-contractors, and finally other WIC programs state-wide.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the health department WIC program has been enhanced in several ways:
1) by developing skills in seminar preparation
2) by exposure to the contacts of the seminars
3) by collaboration with the State WIC agency and
4) by contact with other WIC agencies concerning seminar development and presentation

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Employee turnover reducing training effectiveness. How overcome? Conduct the seminars annually, utilize the buddy system for new employees.	Barrier 2: Scheduling five seminars within one year for three subcontract agencies. How overcome? Use of E-mail to coordinate available presentation dates for all agencies simultaneously and to provide adequate advance scheduling.

5. How is it funded? Other Federal funds.

What is the approximate annual budget for this initiative? $16,230.00

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Measurable objectives were involved in actual seminar development and pilot presentations. Seminar effectiveness was measured by staff termination rates, employee grievances, observed employee/customer relationships, and results of annual client satisfaction surveys.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? It should prove particularly beneficial in a service setting where there is high volume and high demand for the services provided. Employee burn-out and frustration are always a possibility with attendant carry-over to the client.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Knox County Health Department
CITY/STATE: Knoxville, TN

CityMatCH CONTACT: Bea Emory
TELEPHONE: 615/544-4214

CONTACT FOR MORE INFORMATION: Karen Bateman, Elaine Wallace

1a. **Initiative Name:** Enhanced Immunization Tracking/Recall System

1b. **Category(ies) that best applies to your initiative:**
Strengthening Urban Public Health Systems - 43 Immunization tracking, recall systems

2. **Describe the initiative.** Due to the decrease in the immunization rate of children less than 24 months of age, changes needed to be made in the tracking system previously used to include patients of both public and private sources. Newborn mailers, periodic (4,8,19 month) mailers requesting shot information, MMR reminder postcards and overdue cards for public patients were all produced as well as the necessary computer changes to generate the needed information.

   In addition to the mailing, the computer periodically prints a list of vaccine delinquent children. With the use of an auto-dialer, parents are contacted to remind them of needed immunizations. If the child remains unimmunized, then an outreach worker will make a phone call and/or a home visit if needed.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The health department already having an established link through birth certificate registry allowed for implementation of such a tracking system. The initiative was taken following a survey of local private practitioners, most of who provided no recall system and expressed a desire and need for such a system.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The parents of children both public and private have responded positively to our new system and have been very willing to provide immunization information to us. An explanation of the department's role and purpose is explained to parents through the mailers and personal phone calls. Private physicians offices are also cooperating with the additional shot information requests via fax. The perception is that we are providing a needed service to both parents and practitioners.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Computer system changes needed to be revised to accommodate the new registry while not affecting other health department services.

How overcome? A contracted computer programmer was brought in to work with the system and make the necessary changes which involved numerous hours of technical support.

Barrier 2: Creating and producing the new mailers and reminder cards.

How overcome? Through numerous meetings with health department staff and an outside vendor, the mailers were created. Many changes and updates had to be made along the way prior to the actual printing. Once a consensus was reached the printing was completed and the system was activated.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? $20,000 (mailers & postage)

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The computer system generates a list of children who were sent mailers. On this list records are kept when a response is received. One to two weeks following the mailers an automated phone message reminding parents to respond is sent. After this personal phone call/home visits are made.

In 1993 our 24 month old survey indicated a completion rate (4:3:1) of 72.9% of children. Our 1994 survey indicates an increase of almost 10% to 82.3%.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? This initiative could be implemented anywhere a local birth registry is established.

Why? Once this information is available an immunization follow-system can be generated.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Jefferson County
CITY/STATE: Lakewood, CO

CityMatCH CONTACT: Mary Lou Newman
TELEPHONE: 303/239-7001

CONTACT FOR MORE INFORMATION: Irene Bindrich

a. **Initiative Name:** Assurance of Program Outcomes Through the Use of Total Oquality Management (TQM)

1b. **Category(ies) that best apply to your initiative:**
Other - Not Elsewhere Listed - 45 Total Quality Management (TQM)

2. **Describe the initiative.** This project demonstrates that Total Quality Management (TQM) can be utilized as a successful model to assure that consumers are satisfied with program services and outcomes. TQM is a process that is consumer focused, and involves managers and staff is using a systematic approach to measure and evaluate program process and outcomes.

TQM was implemented to evaluate the Health Care Program for children with special needs (HCP) in our county. Our purpose was to improve consumers' satisfaction with HCP services, and improve coordination of HCP administrative duties by state and county health departments. A diagram of each major step in the HCP program was created to ensure consistency in the delivery and outcomes of the HCP program. Problem areas and duplication of services were identified and theories about the causes and efforts of these areas were generated. Data collection was obtained by surveying the HCP staff and families to gather their perceptions and expectations of the quality of the HCP Program.

The survey results revealed that the HCP Program did not meet the expectations of the nursing staff and families. These findings were presented to state and local HCP administrative staff and resulted in the state funding the administrative functions of HCP at our county health department. The decentralization of the HCP will improve access, linkages and utilization of community resources.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** TQM shifts traditional management in measuring programs by consumer standards, implementing methods to obtain consumers' feedback and expectations and involving managers and staff in a proactive approach to evaluate program services and outcomes.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** TQM has provided a model which empowers staff to identify processes that are inefficient, development of strategies to measure the cause and effect of these inefficient areas and implement changes that improve quality of care.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Resistance to new method in program evaluation. How overcome? Training staff in TQM and assisting them in the implementation. Achieving successful results and increasing their satisfaction in delivering HCP services.	Barrier 2: Resistance of State HCP staff utilizing consumers' standards in evaluating services. How overcome? Presenting survey findings as objective data.

5. How is it funded? City/County/Local government funds

What is the approximate annual budget for this initiative? $3,500 (meeting time).

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐ Responsiveness - the willingness of the family to utilize CHN assistance and community services.

14% of the families contacted by the CHN had moved.
38% of the families did not respond to the CHN contact.

Distribution of HCP referrals sent by state:
August - 139 referrals
Sept - 22
Oct - 5

Solution: initiate CHN referrals at the time of the HCP application to improve the timeliness of family contacts.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community? Absolutely.

Why? TQM has been initiated and in the business community for years and is a national trend in improving quality of services and products.

7b. Has this program been replicated elsewhere? Yes, Denver hospitals.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Ingham County
CITY/STATE: Lansing, MI

CityMatCH CONTACT: Bruce Miller
TELEPHONE: 517/887-4311

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Clinic Specific Infant Mortality Study

1b. Category(ies) that best apply to your initiative:
Prenatal Health - 07 Low birthweight/infant mortality

2. Describe the initiative. "Clinic Specific" infant mortality rate was determined by obtaining copies of the birth and death certificates of all Ingham County infants who died during the 1986-1990 period and using identifying information from certificates to determine if the infants who died were born to women who received part or all of their prenatal care at the Health Department's prenatal clinic.

The criteria for including an infant death in the calculation of the clinic specific mortality rate was a minimum of one prenatal visit at the Health Department. Women who were lost to follow-up and women who transferred to providers other than the Sparrow OB/GYN Clinic prior to delivery were not included in the numbers used to calculate the clinic specific infant mortality rate. However, no effort was made to exclude the infant deaths in this group. If women lost to follow-up and women who transferred to other providers had been included, the clinic specific infant mortality rate would have been lower.

The study showed that the rate for infants born to women who used the Ingham County Health Department prenatal clinic was 6.8 per 1000 live births. The infant mortality rate in Ingham county as a whole during the five year period was 9.7 infant deaths per 1,000 live births.

Given the racial mix in the clinic population and the relative risk for infant mortality in different racial groups, the expected infant mortality rate for the clinic population during the time period was 11.2 per 1,000 live births. The actual rate of 6.8 was nearly half of what would be expected given the racial and ethnic mix of clinic patients.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The department designed and conducted the study.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? The department has received considerable publicity as a result of the study.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Not applicable How overcome?	Barrier 2: Not applicable How overcome?

5. How is it funded? City/County/Local government funds; General state funds; MCH block grant funds.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐ Documenting infant mortality in a MCH clinic.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? This initiative might work in other communities that surround pregnant women with a comprehensive array of services.

Why?

7b. Has this program been replicated elsewhere?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: City of Laredo Health Department
CITY/STATE: Laredo, TX

CityMatCH CONTACT: Lisa Sanford
TELEPHONE: 210/723-2051

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Laredo Immunization Coalition

1b. Category(ies) that best applies to your initiative:
Child Health - 10 Immunization
Improving Access to Care - 26 Expanding private sector linkages; 25 Reducing transportation Barriers; 32 Other outreach activities
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. The Laredo Immunization Coalition is composed of the City of Laredo Health Department, Mercy Regional Medical Center (Public, NonProfit), Texas Border Immunization Initiative (Public), Laredo Catch (Community Access to Child Health Care) (Private, Non-Profit), Laredo Independent School District and the United Independent School District. The mission of the coalition is to increase the availability of immunizations to the Webb County Community by pooling resources. The coalition is also committed to the provision of adult health Screening and educational activities.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The City of Laredo Health Department has spear-headed the development of this coalition, chairing the committee and coordinating activities between agencies.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Leadership has been enhanced by strengthening ties with local agencies and increasing the visibility of the health department.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Philosophical difference in the provision of health care. How overcome? Through regularly scheduled meetings held in a central location (breakfast meeting at a favorite restaurant), dialogue has opened up in a relaxed atmosphere which permits and even encourages discussion of philosophies.	Barrier 2: How overcome?

5. How is it funded? City/County/Local government funds; General state funds; 330 funds; Private sources - Sisters of Mercy Texas Pediatric Associations; and Other - Donations from local Merchants.

Each coalition member is self-supporting; activities are provided as in-kind.

What is the approximate annual budget for this initiative? N/A

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The Laredo Immunization Coalition it self does not currently have goals/objectives. These are under discussion at the present time. Here to fore, each agency has completed their required reports, with immunization records being filed centrally at the health department.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?

Why? The coalition is still very young and remains "informal" yet has been effective here. If a close-knit group is formed, I believe it can be replicated.

7b. Has this program been replicated elsewhere? Don't know.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: **Lexington-Fayette County Health Department**
CITY/STATE: **Lexington, KY**

CityMatCH CONTACT: **Regina Moore**
TELEPHONE: **606/252-2371 Ext. 431**

CONTACT FOR MORE INFORMATION: **Carla Cordier**

1a. Initiative Name: Maternity Program

1b. Category(ies) that best applies to your initiative:
Women's Health - 01 Preconception health promotion
Prenatal Health - 05 Expanding maternity services

2. Describe the initiative. The Maternity Program currently provides Comprehensive Maternity Care beginning with an intake visit with the Clinical Assistant, Nurse, and Nutritionist. The visit takes place usually within the same week that the patient requests services. The patient is referred to an OB provider, with whom the agency contracts to provide prenatal care, including various tests and procedures, as indicated throughout labor and delivery, including hospitalization for the mother and newborn, and throughout eight weeks post partum. The program offers preterm labor management. The patient receives nursing/nutrition counseling, off site at the University of Kentucky OB/GYN clinic during the doctor visit, as well as onsite. These services are coordinated with WIC visits as much as possible. The patient also receives home visits prenatally and post partum. The program offers childbirth, prenatal, breastfeeding, and smoking awareness classes.

An expansion of the Post Partum/WIC clinic includes preventive health care, age appropriate risk assessment, pregnant, post partum, breastfeeding risk assessment, and counseling which includes family planning, well child, post partum exam visits, self breast exam, and preconceptional health risk assessment and counseling. Patients are provided these services through eight weeks post partum.

Preconceptional Health services continue as indicated for family planning, pregnancy test visits. Folic Acid supplementation and counseling regarding the relationship to the decrease in the incidence of neural tube defects is included in the preconceptional health counseling as well as during early pregnancy counseling.

Enhanced maternity care which includes providing monthly counseling visit, maternity classes and home visits is offered/provided for those patients who have a provider for medical care but can benefit from these support services.

In February 1994, some of the Maternity Program Clinic and Field Service staff met with the Coordinator of the Mother Baby Unit at the University of Kentucky Medical Center, and coordinated a system which improves the continuity of care for patients seen by both the Lexington-Fayette County Health Department Maternity Program and the University of Kentucky Medical Center OB/GYN staff. This system allows the nurse to obtain needed perinatal information, provide education, answer patient questions, encourage and assist with linking the mothers and their infants to WIC, family planning, post partum, well baby services, and any other appropriate services.

This system was implemented February 16, 1994 and has been successful. Patients have stated that they are appreciative of the visit, especially by someone who they have seen during their prenatal care. Obtaining needed perinatal information is more successful. It is anticipated that more patients will present for services as listed above.

In February 1994 the state Prenatal Program allocated $32,000 to hire a Social Worker in the Maternity Program. The basic objective of this position is to provide social services for Maternity Program clients both on site and at the University of Kentucky OB/GYN clinics. The development of the job description and the recruitment process was a joint effort between the staff from the University of Kentucky OB/GYN Department and the Lexington-Fayette Health Department.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The planning and implementation activities were cooperative efforts between the University of Kentucky OB/GYN Clinic, Private Obstetrician, and the Lexington-Fayette County Health Department staff.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Communication among staff of all agencies and the coordination of patient care of patients seen jointly by these agencies has been enhanced.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Space for staff to provide services is a problem. How overcome? The University of Kentucky OB/GYN clinic staff had renovated their clinic. Space was assigned for our staff to use. Counseling rooms were available at the Health Department on the first and second floors, and the annex. Space continues to be a problem at the Health Department since clients must move to several different areas for a complete visit.	Barrier 2: How overcome?

5. How is it funded? City/County/Local government funds; MCH block grant funds; 330 funds; Third party reimbursement: Medicaid.

What is the approximate annual budget for this initiative? $530,313

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, a program plan and grant detailing objectives and goals is submitted to request state and federal funding. Monthly computerized and manual reports are generated and analyzed. July 1, 1993 through March 31, 1994, 673 Medicaid and non-Medicaid women have been admitted in the program. There have been 2,989 nurse visits provided. There have been 613 participants who have attended classes. It has been projected that 840 women will be enrolled, 3,685 nurse visits provided, and 883 class participants 7/1/93 through 6/30/94.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This initiative could be successful in any area if there is communication and collaboration between those agencies and providers who provide this service.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Lincoln-Lancaster County
CITY/STATE:	Lincoln, NE
CityMatCH CONTACT:	Carole Douglas
TELEPHONE:	402/441-8051

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Teddy Bear Cottage

1b. **Category(ies) that best apply to your initiative:**
Prenatal Health - 04 Prenatal care; 07 Low birthweight/infant mortality
Adolescent Health - 20 Teen pregnancy
Improving Access to Care - 24 Overcoming racial/ethnic/language/cultural barriers; 32 Increasing social support systems

2. **Describe the initiative.** The City of Lincoln, Nebraska has small but growing minority populations. Except for the Southeast Asian community which has primarily settled in one neighborhood, families of minority ethnic cultures are widely disbursed. Health indices reveal that there are still wide gaps between people of color and people of the dominant culture. Infant mortality, late entry into prenatal care and teen pregnancy continue to contribute to high rates of morbidity and mortality among racial ethnic minorities.

The Teddy Bear Cottage was stimulated by the Healthy Homes Project, a CISS-funded minority maternal and child health outreach program in a collaborative effort with the March of Dimes, YWCA, University of Nebraska, Lancaster County Cooperative Extension, and Kiwanis Clubs of Lincoln. The Cottage provides incentives for pregnant women on limited incomes to earn "Teddy Bear Credits" to use in securing clothing and nursery items. Credits are earned by seeking first trimester prenatal care, by keeping prenatal and well child appointments and by making informed decisions related to pregnancy, parenting, nutrition and health. In its first year, the Teddy Bear Cottage expects to serve at least 50 expectant mothers and their children.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** This project was conceived by the staff of the Healthy Homes Outreach program who observed that there were service organizations interested in assisting low income pregnant women. Staff felt that an earned incentive program would encourage behavior changes as well as get participants needed clothing and infant care items.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. This group of organizations had not worked together on a maternal health project before. Also, the project has lead to greater visibility especially in the community using the Hispanic Community Center.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Locating a space in a facility that serves people of all cultures. How overcome? After several failed attempts to find space in a central site appealing to all cultures the group decided to locate the Cottage at the Hispanic Community Center, with space to donate, central to most of the population and on the major bus routes.	Barrier 2: How overcome?

5. How is it funded?

What is the approximate annual budget for this initiative? $3,875

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐ The project has four simple but measurable objectives. Data is collected by the outreach workers from Healthy Homes and reported to the cooperating organizations at regular meetings. To date, the site has been located and marketing materials developed. Merchandise is being inventoried and other service organizations are being approached to participate. We hope to be operational by October, 1994.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This is a replicable project in any community that has service organizations willing to volunteer hours in the Cottage and to raise funds to purchase merchandise. We believe that there are health care providers who are also interested in supporting the efforts if it is successful in achieving healthier outcomes.

7b. Has this program been replicated elsewhere? Yes

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Long Beach Department of Health & Human Services
CITY/STATE:	Long Beach, CA
CityMatCH CONTACT:	Mohamed A. Hafez, MD, MPH
TELEPHONE:	310/570-4042

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Black Infant Health Project

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal care, 07 Low birthweight/infant mortality
Improving Access to Care - 30 One-stop shopping, co-location of services; 32 Other outreach activities; 35 Increasing access to Medicaid
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. In response to an African American Infant Mortality rate in the City of Long Beach which had reached 23.9 deaths per 1000 live births in 1989, the Long Beach Department of Health and Human Services actively pursued additional resources to address the problem.

In January 1991, the Department received funding from the Maternal and Child Health Branch of the State Department of Health Services for a Black Infant Health Project. The project was initially funded for a period of 30 months with a goal of maximizing positive pregnancy outcomes to improve survival rates for African American infants. The project was extended for FY '93-94.

One of the goals of the project was to establish an advisory committee to assist the project in identifying and addressing barriers to adequate perinatal care. An African American Infant Health Advisory Committee composed of 24 members was convened. Included on the committee are community leaders, health professionals, educators, and parents. The Advisory Committee meets six times a year and serves as a coordinating body to ensure access to quality perinatal care for African American women, and survival of their infants, by promoting educational and referral programs within the City of Long Beach.

This project identifies barriers to adequate perinatal care affecting African American women. Outreach and education are provided for the target population through a door-to-door campaign. Women are linked with pregnancy testing, prenatal care, WIC, childbirth education, and necessary support services. Mentor and transportation services are provided for African American women through subcontracts with the National Council of Negro Women and Alpha Kappa Alpha Sorority.

The Black Infant Health Project in Long Beach has become a valuable resource in the City's efforts to decrease infant mortality.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The Health Department has actively pursued additional resources to address the problem of high African American infant mortality. The Department took the lead in establishing the African American Infant Health Advisory Committee. The City Health Officer served as the project director and acted as liaison with the African American community to ensure appropriate presentation in the Advisory Committee.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? This project allowed the Department to link with the African American community and establish a strong public-private partnership with the community resources, agencies, and leadership.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Medi-Cal Application Process/Systems Access

How overcome? Women from the Black Infant Health Project are referred to the Perinatal Access Project. At this "one-stop" center, the women and their infants and children are provided with financial screening and assistance with medi-Cal applications, as well as risk assessment and referral to appropriate prenatal and pediatric providers.

Barrier 2: Involvement of male partners in supporting the appropriate utilization of health care services by pregnant women and their infants.

How overcome? The Health Department has successfully obtained an additional grant from the State of California Maternal Child Health Branch to address this barrier.

5. How is it funded? MCH block grant funds.

What is the approximate annual budget for this initiative? $136,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The project's Scope of Work specifies the measurable objectives and specific data that need to be collected. These include maintaining copies of minutes of the meetings on file, submitting activity summaries, and surveying results, vital statistics, and mortality data in timely progress reports. In addition, summaries of subcontractors' performances are included in progress reports.

Through the program, 343 high-risk African American women have been included and maintained in a network where they receive regular prenatal care, pregnancy-related health education, WIC services, and assistance with other psychosocial needs. The case finding, networking and coordinating function of the BIH program has played a major role in improving the rate of entry into prenatal care for African American women.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This initiative has been successfully implemented in 15 other counties in California.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Sixteen counties in California.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Public Health Programs and Services
CITY/STATE:	Los Angeles, CA
CityMatCH CONTACT:	Irwin Silberman, MD
TELEPHONE:	213/240-8090

CONTACT FOR MORE INFORMATION: Linda Velasquez, MD

1a. Initiative Name: Managed Care Planning Council

1b. Category(ies) that best applies to your initiative:
Strengthening Urban Public Health Systems - 40 Managed care initiatives

2. Describe the initiative. L.A. County has a population of 9.1 million and the highest uninsured population rate in the nation, an estimated 3 million. More than one in four children in California (2.1 million) were uninsured in 1990. L.A. County Department of Health Services (DHS) operates six public hospitals, four of which have emergency rooms and three are level -1 trauma centers. In addition, DHS operates six comprehensive health centers and forty public health centers. DHS has an annual operating budget of over $2.25 billion and in Fiscal Year 1992-1993, Med-Cal (Medicaid) was a source of 43% of the revenue. State-wide uncompensated care of 45.5% is provided in L.A. County and 80.2% of this is provided in County-operated facilities.

With rising medical costs, and a shortfall of funds from the State, DHS began to transition to a managed care system. The State also moved to transition Medi-Cal recipients into managed care plans. L.A. County formed a health care consortium of public/private providers: the L.A. County Managed Care Planning Council with eight subcommittees. The subcommittee on Special Populations was to ensure that categorically funded programs servicing special populations would continue offering those same services to the patients. Children's health issues were given special attention with the formation of the Children's Health Consultant Committee. This committee made recommendations on the major children's programs: California Children's Services, Child Health and Disability Prevention Program (EPSDT), Regional Centers for Disabled Children, School-Linked Health Services, Special Education PL (94-142), and Foster Care among others. This exhaustive process is now at the stage of creating an interim governing body which will organize a permanent board to continue the work of the council. Providing child advocates with an opportunity to participate in this process assures the effective and efficient integration of child health programs and the quality of their health care.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The Department of Health Services has been the leader in organizing, convening, and guiding the process. Senior management has been committed full-time.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? L.A. County DHS has taken a high profile activity and has been notable in including many private organizations in the process.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Communication. How overcome? Open meetings, frequent written evaluations, large mailing lists to keep all informed.	Barrier 2: Dealing with a complicated disjointed health care system. How overcome? Frequent meetings, emphasizing shared goals, including everyone who expressed an interest.

5. How is it funded? City/County/Local government funds; Private source: Participating local care providers.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The measurable objectives of this on-going project will include those currently used to assess the needs of the community.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? There are 10 other counties in California working on similar plans. However, comparisons are difficult due to Los Angeles County's large size.

7b. Has this program been replicated elsewhere? N/A.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Jefferson County Health Department
CITY/STATE: Louisville, KY

CityMatCH CONTACT: Leslie Lawson
TELEPHONE: 502/574-6661

CONTACT FOR MORE INFORMATION: Anita Black

1a. **Initiative Name:** The Neighborhood Place

1b. **Category(ies) that best applies to your initiative:**
Improving Access to Care - 30 One-stop shopping, co-location of services

2. **Describe the initiative.** Seven agencies are working together in one location to provide accessible and responsive services that support the target community, families and individuals in their progress toward self sufficiency. To enhance education, health, employment and other opportunities for success the following public and private agencies have dedicated staff and resources to the Neighborhood Place: Jefferson County Health Department, Jefferson County Department of Human Services, Jefferson County Public Schools, Private Industry Council, Cabinet for Human Resources, Department of Social Services, and Department of Social Insurance, and Seven Counties Services. Services provided on site include child health preventive examinations; immunizations; WIC; family financial assistance; assessments for mental health, chemical dependency and classroom behavior; and screening/referral for employment/training. Neighborhood Place which opened November 30, 1993, is housed in a dedicated area of a public middle school. The staff works together to place clients in all eligible services.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Representatives of the Health Department staff have been involved in the planning of the Neighborhood Place from it's inception. The staff from all agencies dedicated to work at Neighborhood Place began meeting six months before opening in order to become a team. Jefferson County Government (The Health Department is a county agency) has taken a lead role in developing and supporting this model.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, by collaborating with the other six agencies involved in the leadership of the Health Department has become knowledgeable of other service agencies. Also, other community services providers are better informed about Health Department services and are making more referrals for care. Plans are being made to expand this one-stop service delivery model to other areas in the city.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Multiple agencies coming together with seven individual personnel policies.

How overcome? A strong collaborative effort among agency heads resulted in the employees becoming one staff. An on-site supervisor for day-to-day operation of the center was established. An agreement on common work hours, holidays etc. was established.

Barrier 2: All seven agencies have different assessment forms for intake resulting in the client answering the same questions for each agency.

How overcome? A single assessment/intake form to satisfy each agency's requirements was developed, and is now being used along with a common release of information form to share data with participating agencies. This manual system will be computerized in the future resulting in an electronic centralized file.

5. How is it funded? City/County/Local government funds; General state funds; MCH block grant funds; Other Federal funds; Private sources: Neighborhood Companies; Third party reimbursement (Medicaid, Insurance).

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The Health Department portion of the Neighborhood Place has developed measurable objectives for WIC, Child Health and Immunization. The Neighborhood Place is in the process of developing a computerized data collection system that will evaluate the program and provide measurable outcomes.

Most clients who come to Neighborhood Place for one service, leave the center having received multiple services. For example, a family may be seen for emergency help with light and gas bill, the Department of Human Services would help with this problem and before the family leaves will have applied for food stamps, received needed immunizations, enrolled in WIC and signed up for employment assistance. The Health Department's staff involvement with Child Protective Service cases has helped the Center's clients in reducing the abusive pattern of behavior.

6b. Has this initiative been formally evaluated? Each agency provides it's own quality assurance activities. It will be evaluated in the future.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Planning has begun to replicate the Neighborhood Place in another part of the city. The community center offers a majority of agencies available to the residents of that community. Individuals needing services would come to one site and without duplication or excessive travel access needed services.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Madison Department of Public Health
CITY/STATE: Madison, WI

CityMatCH CONTACT: Mary Bradley
TELEPHONE: 608/246-4516

CONTACT FOR MORE INFORMATION: Dolly Marsh

1a. **Initiative Name:** Dane County Vaccinate Infants Promptly (VIP) Project

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization
Improving Access to Care - 26 Expanding private sector linkages; 32 Other outreach activities
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships; 43 Immunization tracking, recall systems

2. **Describe the initiative.** The goal of the CIP project, a joint effort of the Madison and Dane County Health Departments, is to improve the immunization status of children birth to 2 years of age (90% fully immunized by 1996).

A coalition of public and private health care and social service providers, educators, business leaders, community groups and volunteers has assisted in the project design and implementation.

Outreach strategies were developed, including door-to-door contact in targeted neighborhoods, computer recall, and teaming with McDonalds to print placemats with the names/phone numbers of every public health department immunization clinic in the state.

Incentives includes coupons and treats from restaurants and stores, local food products (Oscar Mayer hot dogs!), coloring books and crayons, refrigerator magnets, and thermometers. Celebrities such as Ronald McDonald and University of Wisconsin Basketball Coach Stu Jackson ('SHOTS WITH STU") helped to draw families in.

To reduce barriers to service, immunizations were provided at different times (including evenings) and various new sites such as homeless shelters, methodone clinics, WIC sites, neighborhood centers and even the Chuck E. Cheese Restaurant.

Collaboration with providers such as school districtis, Head Start, United Way, March of Dimes, hospitals, private clinics, and the media has increased awareness and attendance at clinics. A packet of updated information and guidelines was developed and distributed to all providers in an effort to standardize immunization practice.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Madison Department of Public Health has been the lead agency for the VIP Project. MDPH's annual work plan established a Steering Committee as well as the Technology, Education/Outreach, Evaluation, and Immunization Practices Workgroups. MDPH also organized and facilitated the Dane County Immunization Coalition.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, the leadership of the health department has been enhanced as a result of the VIP Project. Many of the outreach strategies and collaborative efforts, including the coalition-building activities of the project, have become models for other initiatives within the department as well as outside the department.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of experience and consistency in media relations.

How overcome? In order to increase comfort in media relations, as well as consistency of information provided, a practice media plan was developed with important information about the project and upcoming activities that was to be used by all staff at each media contact. National Immunization PSAs and announcements were utilized, as well.

Barrier 2: Delays in the development of the computerized immunization database software (MAD VACS), systems adjustment and servicing of hardware.

How overcome? Consultation with a computer programmer outside the department, as well as the State Regional Immunization staff, supplement the department's internal programming capabilities.

5. How is it funded? City/County/Local government funds; Centers for Disease Control (CDC).

What is the approximate annual budget for this initiative? $121,876

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? See major accomplishments described in question 2. Other objectives: 1) Determine baseline immunization levels of county's children. A Retrospective Audit of kindergarten immunization records provided data and will be done annually. 2) Increase overall number of immunizations, with at least a 6% increase in DTP #4. Records indicate a 30% increase in the total number of immunizations of DTP #4. 3) Develop and implement a county-wide immunization registry with tracking system and record database that is accessible to all providers, both public and private.

6b. Has this initiative been formally evaluated? Yes. See 6a.

7a. Do you think that this initiative would work if implemented in another urban community? Yes, this initiative could be implemented elsewhere.

Why? The computerized immunization software is now available at no cost to all public health agencies in Wisconsin. Approximately 70 similar initiatives with funding from CDC are occurring nation-wide.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? See 7a.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Memphis and Shelby County Health Department
CITY/STATE: Memphis, TN

CityMatCH CONTACT: Brenda Coulehan
TELEPHONE: 901/576-7888

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Campaign For Healthier Babies

1b. Category(ies) that best apply to your initiative:
Prenatal Health - 04 Prenatal care
Improving Access to Care - 32 Other outreach activities
Other Outreach - 23.3 Adult education

2. Describe the initiative. Developed in conjunction with Arkansas Department of Health replicating their successful model. Because of contiguity of states, population in E. Arkansas is exposed to Memphis media and tends to use many Memphis health facilities. Campaign For Healthier Babies consists of a media campaign and the Happy Baby Birthday Book - an educational book with coupons which can be redeemed when stamped by the provider on the appropriate dates. Coupons are dated to correspond with appropriate antepartal/postpartal and well child visits. Brochures in attractive stands have been distributed to private and community health providers.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Took the lead and maintained it with assistance of dedicated people from Arkansas.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes - seen as taking a proactive role when media spots are in a (more) prime time than our usual PSA's.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Financing - Both for Production and for Discount. How overcome? Persistence and patience on the part of several people.	Barrier 2: Persuading private providers to display brochures and to participate. How overcome? Again - persistence and patience on the part of outreach manager.

5. How is it funded? City/County/Local government funds, Private source(s): Specify: March of Dimes, 2 Local Private Hospitals, Other: Community Health Agency (State Funded Agency - Arkansas Department of Health).

What is the approximate annual budget for this initiative? First year implementation = $300,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? We are monitoring number of inquiries, number of booklets distributed, etc. However, it is too soon to measure effectiveness reentry into care and number of prenatal visits. Even when we can measure this, Tennessee's entry into Managed Care, January 1994, will probably affect the first year evaluation.

6b. Has this initiative been formally evaluated? No, not yet.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Because we replicated Arkansas' model.

7b. Has this program been replicated elsewhere? Yes, In TN from Arkansas.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: City of Mesquite Health Department
CITY/STATE: Mesquite, TX

CityMatCH CONTACT: Susan Dirik
TELEPHONE: 214/613-0182

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Well Child Program

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization; 12 EPSDT/screenings; 13 Expanded child health services

2. **Describe the initiative.** The most recent initiative for the Mesquite Public Health Clinic in the field of Maternal and Child Health was the establishment almost three years ago of the Well Child Program.

Until recently the City of Mesquite Public Health clinic only offered immunization services two and one half days per week. Funded 100% by the city government, the program allowed for the health clinic to work at a monetary loss of $42,000 per year.

The health clinic staff were reporting consistently that citizens were requesting well child examinations, PKU testing and weight checks for their children. At the same time, the health clinic was meeting all requested goals and had remaining funds to loose one half day per week as long as funding guidelines were not exceeded. Within less than a year, this block grant for approximately $127,000 was awarded.

This grant allowed the health clinic to increase well child services to daily. Within one year of receiving the block grant, the number of children seen in the Well Child Program went up 41%. Within the past year the numbers increased even further by some 34%. Research indicates that this program will serve more than 1000 children by the end of this fiscal year.

Prior to the establishment of this health clinic, the City of Mesquite had only two pediatricians who accepted Medicaid assignment on EPSDT visits.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The health clinic falls under the auspices of the Environmental Health Departments for the city of Mesquite.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The health clinic upon receiving the block grant, was also awarded a continual funding contract from the Texas Department of Health within one year of the initial grant.

Currently, the health clinic offers well child exams five days per week, and immunization services five days per week, two evenings and one Saturday per month. (Immunizations are also included as part of the well child screen). We were also able to drop all residential boundaries which were previously enforced. We were also able to begin accepting Medicaid in both programs.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Political issues at the county level.

How overcome? Patience and time have slowly served to see these issues resolve themselves.

Barrier 2: Pre-conceived notions about what a public health clinic is like.

How overcome? Every effort is made to make the parent comfortable during the process. Plenty of time is allowed for one-on-one parent and nurse question and answer sessions during and after the examination. Every effort is made to offer a clean decent waiting area. Surveys are taken periodically to determine how we can better serve the families.

5. How is it funded? City/County/local government funds; MCH block grant funds; and Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? $72,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Please see the attached data sheet to review how our patient load is charted.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? I believe that community based clinics have a better chance at being able to address the needs of the people they are serving. Community, the term, should mean just that. County levels and districts are too large. Within one county just determine how many communities you have. I believe knowing the need of this community has been the greatest factor toward our success.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: HRS - Dade County Health Department
CITY/STATE: Miami, FL

CityMatCH CONTACT: Eleni D. Sfakianaki, MD, MSPH
TELEPHONE: 305/324-2401

CONTACT FOR MORE INFORMATION: J. Rivera, RN, MSN

1a. Initiative Name: Low Literacy Childbirth Education Program

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal care
Improving Access to Care - 24 Overcoming racial/ethnic/language/cultural barriers
Strengthening Urban Public Health Systems - 36 Staff training; 41 Building coalitions and partnerships

2. Describe the initiative. As part of Florida's Healthy Start Program, which is a statewide initiative to improve birth outcomes, childbirth education was identified as a service that was desired but not available for the medically indigent clients. Our challenge was to prepare childbirth educators and offer childbirth education classes. In order to meet the socially and economically complex needs of the Dade County community, a comprehensive low literacy/culturally sensitive childbirth education curriculum was selected. Currently continuous classes are offered throughout the county at various sites.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Established a mechanism to make available: - childbirth educator training courses; - staff; - budget provision; - establishment of linkages in community; - equipment, physical facilities and support.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? N/A

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of childbirth educators to teach medically indigent low literacy clients. How overcome? Internal recruitment of Public Health Department staff to develop interest in providing classes.	Barrier 2: Space and location that clients could easily access. Security concerns. How overcome? Linked with County/University Hospital for site and utilization of county sites. Security was provided by contract.

5. How is it funded? General State funds.

What is the approximate annual budget for this initiative? $53,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. To improve pregnancy outcomes. Data: - Review of attendance records. - Review of labor and delivery records. - Review of breastfeeding practices, bonding and attachments. Accomplishments: - 32 six-week sessions per year are offered. - 18 instructors have completed childbirth education training. - 80% compliance rate of participants. - Clients' evaluation of classes good to excellent. - Due to clients' satisfaction expansion of the program is being planned.

6b. Has this initiative been formally evaluated? In progress.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Most urban communities have low literacy indigent populations. Utilization of a teaching curriculum similar to one implemented in Dade County could improve birth outcomes for populations at risk.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Other counties in Florida and other states.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Milwaukee Health Department
CITY/STATE: Milwaukee, WI

CityMatCH CONTACT: Elizabeth A. Zelazek
TELEPHONE: 414/286-3606

CONTACT FOR MORE INFORMATION: Sharon Fialkowski (414/286-3616)

1a. **Initiative Name:** Client Tracking System

1b. **Category(ies) that best applies to your initiative:**
Strengthening Urban Public Health Systems - 42 Building MCH data capacity

2. **Describe the initiative.** The Client Tracking System (CTS) is a PC-based automated service documentation record keeping system that effectively tracks clients. CTS provides for a historical picture of clients, families and groups with a major focus on high-risk mothers and infants. The automated record allows for family linkages, comprehensive care plans and quality monitoring of services, including immunization tracking and recall. Individual program modules enable the user to build a customized system. Through data collection and trend analysis, the system will enable the Health Department to target services to Milwaukee's community needs, define health indicators for use by program planners and evaluators and advocate for policy change.

   Integral to the implementation of CTS has been Milwaukee Health Department staff training, the adoption of the Omaha System of clinical documentation, and the building of coalitions and partnerships with local public health agencies. The Omaha System is the standard documentation system used within the department for recording of clinical activities. CTS incorporates this system in its client tracking efforts. The Milwaukee Health Department has taken leadership for the Southeastern Wisconsin Omaha System Interest Group, an ad hoc group that meets twice a year to network and share developments and implications for practice. In the process, local urban MCH local public health agencies review the CTS software and consensually agree on the CTS developments. Linkages have also been developed with the Wisconsin Health Department, linkage will interface with the Bureaus of Laboratories, Consumer Protection and Environmental Health, Vital Statistics, Administration, as well as special programs within the department.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** As above plus, the Milwaukee Health Department has designed the CTS system. It spent 13 years surveying the country for an appropriate document and tracking system. A local needs assessment was completed. Extensive inservicing in the use of the Omaha System Problem List and the interim implementation forms was undertaken with staff and community. The department has also assumed leadership in marketing of the effort statewide.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?**

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of funding.

How overcome? CTS started with a needs assessment that identified critical system capabilities and function. Continual budget requests have been submitted to meet the next phase(s) of the project. On-going evaluation and progress reports are in place to help assure continued high priority placement within the department's budget priorities.

Barrier 2: Staff resistance to change.

How overcome? Every two months an educational inservice is held with case reviews through the team meeting process. The Nursing Division's Continuous Quality Improvement Committee has developed protocols, procedures and support documents and forms to enable the system change. The department's Total Quality Improvement Initiative supports the project and is integral to service delivery.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? Start-up costs of $700,000. Annual budget projected to be 15% of start-up costs plus salaries (network administrator and other support staff).

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Positive responses of local public health agencies and conference presentation participants; Positive staff response and beginning changes in practice; Statewide interest in purchasing the finished product.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? The CTS can be duplicated in other urban communities to support the assessment, assurance and policy development functions of public health.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Minneapolis Department of Health and Family Support
CITY/STATE:	Minneapolis, MN
CityMatCH CONTACT:	Ed Ehlinger
TELEPHONE:	612/673-2780

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Children, Adolescents, and Violence

1b. **Category(ies) that best applies to your initiative:**
Child Health - 14 Injury (including child abuse)
Adolescent Health - 19 Violence prevention/youth-at-risk
Strengthening Urban Public Health Systems - 42 Building MCH data capacity

2. **Describe the initiative.** In response to the increasing public and media attention on violence in Minneapolis, the KIDSTAT program (Child Health Status Monitoring Program) developed a report on Children, Adolescents, and Violence. The purpose of the report was to provide: 1) a structure to assess violence in a community; 2) a set of indicators to measure violence; 3) information on data sources; 4) a review of the gaps and limitations of the data; 5) an assessment of the level of violence as it pertains to children and adolescents in Minneapolis who are either perpetrators, victims, or witnesses of violence; and 6) information that could be used for the development of programs and policies focusing on the reduction and prevention of violence.

Data were collected from existing data sets in a variety of places including vital records, the police department, the public schools, the department of human services, the park department, the Bureau of Alcohol, Tobacco and Firearms, etc. Drafts of the report were reviewed by numerous agencies and individuals in the community to assure accuracy of the data and community ownership of the report. The report was released in a highly orchestrated and publicized fashion to attract community attention and generate community discussion. Copies of the report have been widely distributed locally and state-wide and staff have been available for presentations at conferences and meetings.

Follow-up activities have been initiated with the Hennepin County Prevention Center. Plans are to use the report to stimulate the development of Violence Prevention Coalition.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Minneapolis Department of Health and Family Support initiated the KIDSTAT program as part of its assessment and policy development roles. The issue of violence was chosen by the department and the entire report was written by staff of the KIDSTAT Program. Health Education staff were also instrumental in the release of the document which was well covered by the media.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The Minneapolis Department of Health and Family Support received a great deal of public visibility with the release of the report "Children, Adolescent, and Violence." The report fit well with the Mayor's agenda and we have become more closely linked with her office because of this report. Other agencies in the community have been impressed with the quality of this report and have been calling the department for additional information and for consultation on issues related to violence and data collection.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Difficulty accessing data sources and finding consistent data sources. How overcome? Persistent effort by the author of the report with help from research assistants from the University of Minnesota helped to uncover the necessary data. Many of the inconsistencies in the data couldn't be resolved and those had to be acknowledged in the report. Since one of the purposes of the report was to identify the gaps in the data, this didn't detract from the report.	Barrier 2: Assuring accuracy of the data. How overcome? As we reviewed the data it became evident that much of the data from several of the sources was inconsistent and inaccurate. This was resolved by constant iteration with the person supplying the data. When the person supplying the data realized that their name would be included as a reference, the accuracy of the data improved.

5. How is it funded? City/County/Local government funds

What is the approximate annual budget for this initiative? $20,000.00

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The evaluation of this report consists of identifying what program and policy changes occur in the community relative to children, adolescents, and violence. To date the following have occurred:

- the electronic and print media have provided extensive coverage of the report,
- the media have used data from the publication in other articles/reports,
- a local foundation has pledged money to anti-violence activities,
- copies of the report have been sent to local foundations with a letter from the mayor suggesting that they focus some of their resources on violence reduction programs,
- the Minnesota Public Health Association will use the report as the basis for proposing some legislation in the next legislative session,
- the University of Minnesota College of Education used the report as the needs assessment for a grant application to develop an Associate of Arts degree in violence prevention,
- the 4th Judicial courts were planning a community forum on family violence and have expanded the scope of their forum because of the report.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? This report could be implemented elsewhere.

Why? In fact, this type of report is one of the core functions that should be done by local public health agencies. This type of report could be done more easily now because many of the data sources have been identified. Violence is a major problem in most urban areas. This type of report would help make violence a public health issue and put the local health department in a leadership role.

7b. Has this program been replicated elsewhere?

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Missoula City/County Health Department
CITY/STATE:	Missoula, MT
CityMatCH CONTACT:	Carol Regel
TELEPHONE:	406/523-4750

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Immunization 0-2 Years

1b. **Category(ies) that best applies to your initiative:**
Child Health - 10 Immunization

2. **Describe the initiative.** In January 1992/1993, the Montana Department of Health & Environmental Sciences initiated a strategic planning session for counties in Montana regarding the immunization status of our children 0-2 years of age. The declining of up-to-date immunizations was evidence of a current system that was not effective in serving our children. The Initiative resulted in providing monies to our community for the promotion and enhancement of immunizations. The components addressed public awareness, tracking and surveillance, and increased the opportunities for immunizations.

The Public Health Nurse initiated efforts to enhance public awareness. This included media efforts through PCA's Television/Radio interviews, Board of County Commissioners announced a Proclamation for Pre-School Immunization Week. The Neighborhood Public Health Nurses expanded the availability of immunizations in their neighborhood areas with extra clinics outside of the Health Department. Immunizations were offered at the local mall, Urban Indian Center, Head Start, Day Care Centers, YMCA, and Low Income Housing areas.

Parents of all newborns in the County are notified with a reminder letter of immunizations due at 3 months, 5 months, 7 months, and 15 months. A computer tracking system is used to alert the clients already receiving immunizations at the Health Department of immunizations due.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Department has been the lead agency in developing the collaborative effort with the local organizations and the local physicians.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** As the visibility of the Health Department has increased, the community has become more aware of the services that can be provided, and local organizations are volunteering to be a part of the effort. The local Kiwanis Group has been financially and physically supportive. Local homemakers are volunteering at the Western Montana Fair Immunization Booth and McDonalds is organizing a collaborative Public Awareness campaign.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Financial resources. How overcome? Granted monies - for the initiative to improve immunizations for 0-2 years.	Barrier 2: Community awareness and lack of collaboration with physicians. How overcome? PSA's, planned mini-workshops with physicians' offices. Strengthening interagency relationships.

5. How is it funded? City/County/Local government funds; Other Federal funds.

What is the approximate annual budget for this initiative? $200,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? By year 1996, the immunization levels for all Montana children will equal or exceed 90% fully immunized, with all recommended vaccines by age 2 years. Measurement of immunizations provided on-site by age and type of vaccination. Assessment of Day Care levels of immunizations. WIC immunization records at the beginning of the project and one year later. Number of notifications sent to parents of children who have received immunizations through the Health Department, but have not returned when the next immunization was due. Maintain the immunization reminder project for parents of newborn infants and continue with the telephone call at 7 months to determine immunization compliance.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? The current trend of the Health Community will enable the project to be replicated.

7b. Has this program been replicated elsewhere? Yes.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Mobile County Health Department
CITY/STATE: Mobile, AL

CityMatCH CONTACT: Joe M. Dawsey
TELEPHONE: 205/690-8115

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Poor Pregnancy Outcome Review Team

1b. **Category(ies) that best applies to your initiative:**
Child Health - 07 Low birthweight/infant mortality

2. **Describe the initiative.** In an effort to improve the quality of health care given to the pregnant women and young children of our community, the Mobile County Health Department Women's Center convened a Poor Pregnancy Outcome Review Team. The purpose of this multidisciplinary team is to identify trends or programmatic problems that negatively impact on pregnancy outcome. Proposed solutions to identified problems are discussed and appropriate follow-up is done.

The review team consists of a nutritionist, social worker, perinatal coordinator, clinic administrator, preconceptional counselor, nursing supervisor, and a medical care provider. The team meets bimonthly for one hour to review the charts of maternity patients who have experienced a low birthweight delivery (less than 2,500 grams), fetal death, or infant death. Approximately 170 charts are reviewed with a summary of maternal and infant care events to review. Each case is discussed at the meeting with individual members providing insight according to their area of expertise as to the appropriateness of care that was given.

This program has proved very beneficial in the improvement of patient care services offered. Efforts of the review team have resulted in many patient flow and programmatic changes within the existing clinic system as well as the initiation of many new patient care activities, all of which serve to enhance the level of quality health care provided to our patients.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Department has been the leader in this initiative.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Program management for patient care has been enhanced.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Time lapse in getting information for chart review. How overcome? Get information directly from hospital where patient delivered for team review.	Barrier 2: Arranging team meeting time. How overcome? Scheduling at a specific time every two weeks rather than on an as-needed basis.

5. How is it funded? MCH block grant funds; Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? No separate budget.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The MCH initiative has the objective of helping reduce poor pregnancy outcome. This is a specific measurable objective. The data is collected on birth certificates and discharge summaries for team review. The major accomplishments to date include changing patient rotation so service area will not be missed such as WIC and Social Services. It is still too early to determine overall reductions in poor pregnancy outcomes.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? This initiative would work in other urban communities.

Why? It is very easily implemented if different professions work together. Our most difficult job was getting the physician providers' commitment to attend the meetings.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Stanislaus County Health Department
CITY/STATE:	Modesto, CA
CityMatCH CONTACT:	Cleopathia L. Moore
TELEPHONE:	209/558-7400

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Building Coalitions and Partnerships

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal care
Women's Health - 01 Preconception health promotion

2. Describe the initiative. In 1991, the Stanislaus Minority Community Health Coalition was formed to plan, advocate and actively coordinate community involvement to allow various ethnic minority groups to identify their specific health care needs, resources, and to work with them and other health care providers with finding potential solutions associated with those identified health care needs. As a result, a door-to-door survey was carried out to assess needs identified by the community. These findings were articulated to the Board of Supervisors, media, providers of health care, as well as the State Department of Health. The Coalition has subsequently been included in health care planning for the community, with representation to the Children's Interagency Council, Managed Care Steering Committee, State Department of Health meetings and other forums that address health care needs in Stanislaus County.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The Health Department allowed the MCH Director to Chair the Coalition and attend State and local meetings, provided in-kind services, provided space for the initial open house of the Coalition and, where needed, supplies and use of equipment (computer), etc.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes. The Health Department has taken a more active role in the community, been included in any meetings that have to deal with identifying or planning to meet the needs of the community, whether health related or not. The Department is considered expert in working with the community; obtaining community support and being able to articulate the problems, concerns, etc. of the community.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Initially, keeping the momentum and interest of the coalition.

How overcome? Presenting concerns, allowing the members to all actively participate in problem-solving. Writing for the grant which allowed more active participation and provided some direction.

Barrier 2: Funding, establishing credibility in the community and among health care providers.

How overcome? Again, through the grant awarded by the State Department of Health Services (7/92) we were able to obtain funding to start addressing our concerns through identifying those of the community. Through support of the local media, community organizations, the Public Health Department and Mental Health Department, the Coalition began to be recognized. The MCH consultant (State) allowed this activity to become one of the objectives for the MCH Block Grant.

5. How is it funded? City/County/Local government funds; MCH block grant funds; Private sources: Omega Nu, Christ Unity Baptist Church, Sierra Foundation.

What is the approximate annual budget for this initiative? $30-50,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? No. The initiative is evaluated by the inclusion of the Coalition in planning, assessing the needs of the community, how often our document is requested by those organizations seeking funding to meet the community needs and how often the Coalition is drawn upon to serve as a broker of services. Accomplishments: 1) Survey tool, completion and analysis of survey; 2) serve as representative to Children's Coordinating Council; 3) serve as chair to local Managed Care Committee on Multicultural Health; 4) received funding from Omega Nu 6/94 for purchase of a computer;. 5) asked by Sierra Foundation to participate in urban grant to address needs of children 0-8 in our community; 6) the only Multicultural coalition of its kind in the State of California with representation from the Asian (Hmong, Lao, Cambodian), Afro-American, Caucasian and Hispanic communities.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Whenever there is diversity of people with common concerns, specifically health care and social issues, a common bond is established. The only ingredient needed is perseverance and commitment.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Metropolitan Health Department of Nashville/Davidson County
CITY/STATE: Nashville, TN

CityMatCH CONTACT: Betty Thompson, RN
TELEPHONE: 615/340-5648

CONTACT FOR MORE INFORMATION: Joan Clayton-Davis

1a. **Initiative Name:** Metropolitan Nashville Stroke Belt Initiative

1b. **Category(ies) that best applies to your initiative:**
Improving Access to Care - 27 Clergy and health connections

2. **Describe the initiative.** The Stroke Belt Initiative is a community-based, risk factor reduction initiative designed to reduce stroke in the African American community of Nashville, Tennessee. The program is designed to 1) train a team of church members to work together effectively as a team; 2) plan, implement, and evaluate stroke related health promotion activities; 3) conduct risk reduction activities in the community; 4) assist in training other church-based health promotion teams; and 5) assist the public health department in finding ways to address health disparities in the African American population. Team training consists of six (6) training sessions, each 1-1/2 to 2 hours held at a church location. Topics include:

Session I	Introduction to Stroke
Session II	Team Building
Session III	Meeting Management
Session IV	Community Resources and Healthy People 2000 Objectives
Session V	Planning Health Promotion Activities
Session VI	Implementing and Evaluating Health Promotion Activities

Health department staff continue to meet with teams to provide technical support; assist them in becoming involved in community coalitions that focus on addressing health disparities in African Americans, and assist in using the media to publicize activities of the teams or to get risk reduction messages to the public. The key element of the Stroke Belt Initiative is the development of working partnerships with African American churches to address health issues. All activities are planned by the churches with support from the Metropolitan Health Department.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Metropolitan Health Department staff developed the training program, recruited participating churches, trained church based health promotion teams, and continue to provide technical assistance in the development, implementation and evaluation of stroke related activities held in the church or the communities they serve. Technical assistance examples include: 1) training health promotion team members to conduct training sessions for other churches; 2) developing and conducting a survey as part of a needs assessment; and 3) developing an intergenerational stop smoking campaign.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Leadership of the health department has gained invaluable insight into the process of developing effective partnerships with African American Churches as a vehicle for transmitting health care from the public health arena to targeted groups in the community, especially the African American community.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Identifying churches and church team members willing to make a long term commitment to health promotion in their church and community.

How overcome? 1) Outlined roles and responsibility of each partner in the Stroke Belt Initiative and each church submitted a Participation Checklist to the health department. 2) Involved church leaders in all aspects of the program from decisions to participate, selection of team leader and team members, selection of activities to implement, to approving needs assessment instrument (survey questionnaire) and how it would be conducted at the church, and how data would be presented back to the congregation.

Barrier 2: Overcoming suspicions about African Americans being used for research only, rather than providing service to the community and suspicion about one time/short term projects.

How overcome? 1) Spent 1-3 months in program development meetings with church leaders to ensure there was a clear understanding that the initiative rests on an ongoing equal partnership. 2) Framework for establishing teams was built on the church assuming responsibility and a commitment to maintain the team as an ongoing aspect of its outreach efforts. 3) Ensure that the health department had as much background on each church as possible, especially past outreach efforts and community involvement of the pastor and other church leaders.

5. How is it funded? City/County/Local government funds; Other Federal Funds - NHLBI.

What is the approximate annual budget for this initiative? $31,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Objectives include training at least two (2) church-based health promotion teams who must conduct at least one (1) community activity each year. Data for planning activities is collected via a 14-question church member questionnaire that collects data on individual and family experience with stroke, high blood pressure, and diabetes, lifestyle issues, and knowledge about stroke and health disparities in African Americans. Three (3) teams have been trained in the first year of the program. More than 300 individuals have completed church member surveys. A children's (intergenerational) stop smoking contest/campaign has been developed and implemented. Health promotion activities such as blood pressure screening, health fairs, nutrition seminars and walking clubs have been implemented or are planned. Three media stories have been aired and one newspaper article published in year one of the program. Teams evaluate each training session and an overall training. Activities are evaluated as conducted.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? This initiative could be replicated in other urban communities and can be instrumental in targeting special or at-risk populations.

Why? The use of church-based teams can enhance efforts to address health problems that impact health disparities in African Americans or other ethnic groups. This approach can be implemented in small, medium size, or large church congregations utilizing volunteers who have health related backgrounds or no health backgrounds.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Newark Department Health and Human Services
CITY/STATE:	Newark, NJ
CityMatCH CONTACT:	Juanita Larkins
TELEPHONE:	210/733-7591

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** TB Task Force

1b. **Category(ies) that best applies to your initiative:**
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, TB, HepB

2. **Describe the initiative.** The TB Task Force consists of health care providers from local area hospitals, the municipal, county and state health officers and other health care providers thought to be experts in the area of tuberculosis. The task force developed a survey and conducted surveys to collect data regarding the control measures which are currently in place for employees in our health care systems, schools inclusive of colleges and universities. Further the task force questioned the validity of available data and wanted to perform pilot studies on five (5) populations of individuals within our jurisdiction to replicate or dispute the available data.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Newark Health Department has functioned as the coordination point for activities conducted by the Task Force and has earned our two pilot TB screening projects.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** I'm not sure what this question is asking, however, the Health Department is perceived as now being interested in working with local hospitals to conquer this problem. The six hospitals in our community usually cannot all sit at the same table to discuss a common goal.

4. **What have been the greatest barriers faced in implementing this initiative?**

Barrier 1: Getting all the players to come to the table. How overcome? The hospital CEO's were contacted via letter, telephone and in some instances in person. They were requested to assist in motivating their chief of pulmonary medicine to willingly join the task force.	Barrier 2: Overcoming egos of each specialist. How overcome? All of the chiefs had difficulty bowing to each other. Each felt their method of operation was the only way to go. We assigned each chief an objective of the overall task force for which she/he was specifically responsible.

5. How is it funded?

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?
Yes!! Data is collected via reports, in some cases daily, weekly or monthly.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?
Yes

Why? It is very flexible and can be tailored to suit any urban community.

7b. Has this program been replicated elsewhere? I Don't Know.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: New Haven Health Department
CITY/STATE: New Haven, CT

CityMatCH CONTACT: Catherine S. Jackson
TELEPHONE: 203/777-5950

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** "First Steps to Healthy Child Development"

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 06 Home visiting
Child Health - 11 Early intervention/zero to three
Improving Access to Care - 24 Overcoming racial/ethnic/language/cultural barriers, 33 Increasing social support systems, 34 Case management/care coordination
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** "First Steps" serves working families with children in city daycare at the New Haven Child Development sites. The goal is to link daycare staff and clients with health care information and resources, and to ensure that each enrolled child is securely linked with a primary pediatric caregiver. Paraprofessional outreach workers based in the New Haven Health Department and in the City daycare agency provide family support services to families of children who may have medical, mental health or developmental problems.

Major goals of the program are: 1) ACCESS TO HEALTH SERVICES: to ensure that Head Start and children of families transitioning from welfare into employment receive timely, regular and comprehensive health, mental health and developmental services; 2) ACCESS TO OTHER NEEDED SERVICES: to assist parents in securing other services (e.g. behavioral consultations, advocacy, housing) to promote healthy child development; 3) PARENT EDUCATION IN HEALTH & CHILD DEVELOPMENT: to communicate appropriate health education and child development information to parents of the above children in settings and in ways which will enable parents to make effective use of this information on behalf of their children.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Department collaborates with the City daycare agency, Yale Child Study Center, Yale-New Haven Hospital, Hill Health Center and citywide Childcare Coalition to develop goals and objectives, job descriptions, workplans, training and supervision for the outreach/family support workers, provide education for families and monitor referrals.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the health department has been enhanced in the following ways: 1) by expanding expertise of MCH home-visiting workers to child health issues beyond infant, 2) by demonstrating ability to collaborate with other agencies in planning, implementing, monitoring, and evaluating the new program.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Getting people from different programs to work together without turf battles.

How overcome? Historically, none of the groups (health, daycare, Head Start, hospital and community health center) had worked together in an integrated way. The agencies involved had to develop a strong commitment to our shared goal (connecting families to resources) in order for this initiative to work. To tackle turf issues and bureaucratic idiosyncracies that obstructed progress required many meetings and continual networking and relationship-building across traditional agency boundaries.

Barrier 2: Obtaining reliable health information on the children; poor communication between health providers and childcare providers.

How overcome? We had to develop new common forms which would capture the information needed on the children and persuade (and train) all staff to use them routinely.

5. **How is it funded?** City/County/Local government funds; Private sources: United Way/InfoLine; Third Party reimbursement: Medicaid.

What is the approximate annual budget for this initiative? $125,000

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?** Program objectives are: a) 90% of parents of enrolled children will attend the educational workshops and evaluate them positive; b) a minimum of 15 referrals to this program in year one, and 90% of referred children will be linked with needed services. The Childcare Coalition Project Coordinator records the numbers of parents attending workshops, numbers of referrals received and acted upon, and numbers of successful linkages. A team of Yale MPH students conducted a study comparing the charts of 223 enrolled children in initiative with 240 other New Haven Child Development children not enrolled in the First Steps program. This study showed that 24 Care Plans were developed in one year for the enrolled (experiment) group, versus seven Care Plans for the control group. Thus, 77% of the total Care Plans that year were initiated by the group enrolled in First Steps, demonstrating that identification of health and developmental problems and of intervention was significantly greater with the outreach workers in place.

6b. **Has this initiative been formally evaluated?** Yes.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes.

Why? This initiative would certainly work in other urban communities, because working parents have new stressors from employment demands on their time and can benefit from the support of a child health educator/role model who provides family support. Both clients and staff benefit from collaborating. The staff of City Daycare became well-versed in health and mental health resources, learned when and how to refer children they previously considered behavioral problems, and witnessed the value of early mental health interventions by the Yale Child Study Center personnel. Medicaid payment was obtained for families whose children (still) qualified through an eligibility expansion (Healthy Start) even though the parent(s) were employed. In addition, hospital and health center personnel developed appreciation of city MCH workers' expertise.

7b. **Has this program been replicated elsewhere?** No.

If yes, where?

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1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	New York City Department of Health
CITY/STATE:	New York, NY
CityMatCH CONTACT:	Gary C. Butts, MD
TELEPHONE:	212/788-5331

CONTACT FOR MORE INFORMATION: Carmen Ramos, MD

1a. Initiative Name: Community Interpreter Project

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal Care; 05 Expanding maternity services

2. **Describe the initiative.** Over 28% of New York City residents are foreign-born, with one in five New Yorkers unable to communicate in English. Non-English speaking patients are less likely to access or effectively utilize available health services. Impacting on their health status and that of the community. Use of children, and other untrained bi-lingual individuals as interpreters may cross some linguistic barriers but has major implications including loss of detail and accuracy critical to medical/psychiatric interviews.

   In 1992, in response to the challenge of providing health services in a multilingual city, and understanding the impact on the community's health when this challenge is ignored or not adequately addressed, the Hunter College Center for the Study of Family Policy, in collaboration with the NYC Department of Health, NYC Health and Hospital Corp., and Bellevue Hospital Center established an innovative program which trains Hunter College bi-lingual undergraduates to be simultaneous medical interpreters. Students receive academic credit for interpretation training and for on-site interpretation at Bellevue and DOH Child Health Clinics.

   The Community Interpreter Project provides intensive training workshops and class sessions on which students hone their language skills, develop skill in consecutive and/or simultaneous interpretation, develop glossaries of medical terms, and discuss the delivery of health care and issues of immigration and settlement.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Bureau of Child Health conducted a survey of all 46 Child Health Clinics to determine the language spoken by clinic staff, and then worked with Hunter College in determining clinic assignments in order to match the clinic needs with the students' language and interpretive skills. We developed the glossary of medical terms used by the students in interpreting and participated in the orientation sessions on health care delivery given to students. The Bureau collaborated with Hunter College in designing and developing the grant proposal for funding of the project.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, this project has enhanced cross-cultural sensitivity and increased awareness of linguistic diversity, and will thus help us in our ability to address health care concerns of our immigrant population.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Staff resistance and uncertainty about how to effctively use and integrate the student interpreter in the clinic operation.

How overcome? By individual orientation and counselling of staff.

Barrier 2: Insufficient number of families requiring interpretation during a clinic session to keep the student busy.

How overcome? This problem was addressed by working with clinic receptionist to plan schedules so that non-English speaking families had appointments at the same time the students were assigned to the clinic.

5. How is it funded? Other federal funds - Federal Department of Education Funds for the improvement of Post-Secondary Education (FIPSE); Private sources - Fund for the City of New York, New York Community Trust, Aaron Diamond Foundation, Starting this year - W.K. Kellog; Foundation, under the Division of Philanthrophy and Volunteerism.

What is the approximate annual budget for this initiative? 1993 - $150,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Three targets of impact: 1) Students: Their interpretative skills, self-esteem and attitudes toward volunteerism; 2) Staff satisfaction; 3) Patient satisfaction.

During the first year, 60 students provided 3500 hours of interpretation to New York City Department of Health Child Health clinics and selected health and hospital facilities.

6b. Has this initiative been formally evaluated? Formative evaluation consisting of surveys of staff and student satisfaction were done the first year. Impact evaluation will be done this year.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This program can serve as a model for replication because it demonstrates partnership and capacity building, and the ability to develop cooperation between a public health care agency and a teaching institution with tremendous student resource and diversity.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: New York City Department of Health
CITY/STATE: New York, NY

CityMatCH CONTACT: Gary Butts, MD
TELEPHONE: 212/788-5331

CONTACT FOR MORE INFORMATION: Rose O'Keefe Block

1a. **Initiative Name:** New York City Child Health Plus Outreach Campaign

1b. **Category(ies) that best applies to your initiative:**
Child Health - 13 Expanded child health services

2. **Describe the initiative.** In 1990, New York State enacted the Child Health Plus (CHP) program to provide health care coverage to the state's uninsured children for free or very low cost to parents. Because a large portion of the target population for the program resides in New York City, the state established the New York City Child Health Plus Outreach Campaign in 1992 to market and educate parents about the availability of the insurance. This Outreach Campaign has proven to be extraordinarily successful at enrolling children and reaching out to a diverse range of communities and cultures. Through an innovative approach of large-scale open houses, collaborative efforts with private insurance plans, and network-building, the Campaign quickly met goals set by the state, while developing a highly responsive information and assistance system.

In New York City, at least a quarter-million children have no health insurance. Most are poor and many are newly arrived immigrants and non-citizens. The Child Health Plus program covers these children for primary and preventive care services up until the age of 14. But reaching these children is a challenge given language barriers and distrust of public programs.

The success of the Outreach Campaign where similar efforts have failed is direct result of its cooperative creative approach, which cuts across typical lines of government authority. For one, it is a truly collaborative project of the Medical and Health Research Association of NYC, Inc., the New York City Health Department (DOH), and the New York State Department of Health. More importantly, support is enlisted from private health plans, community-based organizations, foreign embassies, and other city agencies through extensive training of their staffs so they can also inform parents about the program.

Another key component is the use of grassroots, outreach workers who conduct large-scale open house events in prioritized communities, using community-based organizations for translation assistance. The targeted communities were identified through a needs assessment in a marketing plan developed at the beginning of the Campaign.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Outreach efforts for Child Health Plus were facilitated through the DOH's leadership role in the professional community. DOH management linked the Outreach Campaign with their clinics and programs to reach poor working families and immigrants; NYS Department of Labor to reach recently unemployed families without COBRA benefits; NYC's Human Resource Administration (HRA) Medicaid insurance program to reach all children under age 14 who are rejected from Medicaid, hence eligible for Child Health Plus. Staff is currently working on their first linkage to a federal agency.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** More than 30,000 children have been enrolled since CHP's inception which has reflected very positively on DOH. Enrollment has steadily increased, communities now believe this is a legitimate program rather than an insurance scam and more children are receiving preventive services. Child Health Plus represents DOH's commitment to new and innovative programs, its ability to keep pace with the changing face of health care and health care delivery to poor people.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: The greatest barrier faced was widespread skepticism of government social programs in high need communities.

How overcome? Traveling under the banner of DOH, campaign staff forged an integrated network of neighborhood organizations, community activists, contracted health plans and immigrant advocates to promote Child Health Plus. Strategies include training these organizations to fill out applications, asking them to translate material into 8 different languages, distributing materials to parents regularly and co-hosting enrollment events.

Barrier 2: Locating undocumented families and getting them to trust the people responsible for enrolling their children in Child Health Plus.

How overcome? Strategies for overcoming this fear include using the community-based and immigrant advocate organizations to help staff explain the program to undocumented parents and stress that immigration status would not be affected; hiring bi-lingual and bi-cultural staff; producing information in 8 languages; and asking each parent contacted to tell their families and friends about the program thereby capitalizing on word-of-mouth advertising.

5. How is it funded? General state funds; Other: NYS Bad Debt and Charity Care Pool.

What is the approximate annual budget for this initiative? $250,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? This initiative has specific objectives with data collected and reported in a monthly and quarterly narrative format measuring the number of: materials distributed citywide, CBO's and agency staff trainings, calls from parents to the bilingual hotline, meetings, professional trainings, presentations to parents and enrollment events. The major accomplishments to date are: Increasing citywide enrollment 70% by the third month of the Campaign's existence, creating the Child Health Plus language bank, co-sponsoring key events in the city geared to families with children under age 14, reducing the number of uninsured children depending on NYC DOH episodic care clinics and linking them to on-going primary care, developing linkages with public schools, Medicaid, the NYS Department of Labor and community based organizations to identify eligible children and enroll them in Child Health Plus.

6b. Has this initiative been formally evaluated? Currently in progress.

7a. Do you think that this initiative would work if implemented in another urban community?

Why? The success of this initiative can be duplicated in other urban communities because it is explicitly built upon familiar as well as recognized multiple levels of organizational structures and resources which were then integrated into an informed and coordinated outreach plan by the staff of the campaign.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Norfolk Department of Public Health
CITY/STATE: Norfolk, VA

CityMatCH CONTACT: Joyce L. Bollard, RN
TELEPHONE: 804/683-2785

CONTACT FOR MORE INFORMATION: Lisa Manley, MSW (804/531-2132)

1a. Initiative Name: Real Alternatives to Pregnancy (RAP) Program

1b. Category(ies) that best applies to your initiative:
Adolescent Health - 20 Teen pregnancy

2. Describe the initiative. There are three (3) major components of the RAP Program:

1) "Train the Trainer" and subsequent staff training for all youth serving agencies designed to target at-risk youth through a multi-agency, consistent community message regarding pregnancy prevention, sexually transmitted diseases, HIV/AIDS, prenatal care and parenting skills. This training was contracted out to a certified Sexuality Educator.

2) RAP Program staff includes medical social workers and a public health nurse who are equipped with "beepers" so that the community (especially staff in youth serving agencies) have immediate access to them to facilitate education, consultation, counseling, and referral. Staff will visit anywhere in the community.

3) RAP staff have done direct individual counseling to youth and families as well as group education such as "all night lock-in" groups in churches and recreation centers and with Youth Councils. Additional work has been done in coalition building. One example which promoted ownership of the program was accomplished through mini-initiatives where notice was sent out to community groups informing them if they wanted to do a program or project to foster teen pregnancy prevention, they could submit their plan for review and that eleven (11) projects for $1,000.00 each would be funded. There were many submitted and the eleven selected represented a wide perspective on dealing with teen pregnancy prevention.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The health department is an equal partner in the collaborative approach to solving community problems and is seen as the leader in providing population based public health services.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes, fifty-four (54) community agencies or groups have been identified as referral sources to the RAP program and all have been contacted and the program marketed with referral mechanisms implemented.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Staffing due to use of part-time staff. How overcome? Hired full time staff with improved benefit package.	Barrier 2: How overcome?

5. How is it funded? General state funds; and Other - Matching state and local support.

What is the approximate annual budget for this initiative? $190,000 per year

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, both quantitative and qualitative evaluation of specific measurable objectives collected quarterly. Use of pre and post testing of youth serving professionals who are trained in the program. Approximately, 100 youth serving staff from over 20 agencies have been trained. There have been over 1,500 targeted youth individually counseled in the first year. Referral mechanisms implemented with 54 community agencies/groups.

6b. Has this initiative been formally evaluated? Yes. Evaluation is on going by Virginia Commonwealth University, Research Center.

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? However, it is absolutely necessary for the local community to determine that there is an agreed upon need and that the various parts of the community have collaborated and designed their unique approach to meet the need (within their community values, ideas, etc.).

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	City County Health Department of Oklahoma City
CITY/STATE:	Oklahoma City, OK
CityMatCH CONTACT:	Loydene Cain, RN, Program Administrator Women's Health
TELEPHONE:	405/425-4405

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Alcohol & Drug Abuse in Pregnancy-Prevention & Training (ADAPPT)

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 08 Substance abuse prevention/treatment

2. **Describe the initiative.** Through the development of a multilevel prevention and service coordination program, the project seeks to improve and expand services throughout the state to substance abusing women who are of childbearing age. The project will address the following three goals: 1) Promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for substance using pregnant women and their infants. 2) Increase availability and accessibility of prevention, early intervention and treatment services for low income women of childbearing age. 3) Improve the birth outcomes of women who use alcohol and other drugs during pregnancy and to increase the incidence of infants affected by maternal substance use.

To achieve these goals there will be six categories of project activities: 1) Community Organization and Networking: a) Development of a community needs assessment and Task Force; b) Identification of gaps in services and barriers to care; c) Work to augment, enhance, or modify the services to better serve the needs of childbearing age women. 2) Within the Family Planning and Maternity Programs, pilot techniques to better identify the women with a substance use problem. 3) Outreach to identify and bring into care women with a substance use problem, who are not being served in the public health systems. 4) Case management services provided for one year after inpatient drug treatment or delivery of a drug exposed infant. 5) Professional's educational activities (instrumental to obtaining project goals); 6) Evaluation plan and sharing what learned.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** 1) Educator; 2) Developed and implemented community needs assessment; 3) Organized and coordinated community multi-disciplinary Task Force; 4) Developed and printed brochure concerning the service that was based on client input; 5) Obtained nationally known speakers that taught on the subject of Perinatal Substance Abuse; 6) Active participation in State Legislative committees who addressed legal and statutory concerns; 7) Assisted in development of new treatment centers and expansion of existing ones; served as consultant on advisory boards of treatment centers; 8) Organized Physician Panel discussion/presentation for health care professionals and students on Perinatal Substance Use issues; 9) Developed a Physician information Packet and mailed to all Obstetric and Family Practitioners; 10) Asked to participate on Fetal and Infant Mortality Analysis Review Board; 11) Via the Task Force, systems' level changes, in all participating agencies, introduced and implemented concerning priority to pregnant women.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. Successfully addressed the issue of perinatal substance use/abuse, demonstrated that we can be responsive and not just reactive to the needs of the community. Faced and addressed our fears by not being judgmental, we are better able to be there for our citizens. We proved that issues must be faced and not ignored. Opened the door for other "taboo" issues such as domestic violence. Exposed the community to the holistic health approach.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Access to clients for case management and follow-up difficult because of attitudes of professionals (stereotyping, judgmental, and fear) and Policies and Procedures that require referral (out of our clinics) of all "high risk" prenatals (including those women who ever had a history of substance use). How overcome? Education on the subject of Perinatal Substance Use/Abuse/Effects. Instrumental in getting the high-risk referral criteria changed (on a State level).	Barrier 2: Our own agency (internal) accounting system. How overcome? Grant monies designated for direct client assistance, i.e., transportation, child care, emergency assistance, etc. Contracted with an outside, private, non-profit organization to implement; resulting in agency writing a check to the vendor and not the client.

5. How is it funded? Other Federal funds - Office for Substance Abuse and Prevention

What is the approximate annual budget for this initiative? $53,518.00

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. Monthly referral log; Monthly monitoring of waiting lists of treatment centers; Reduction in Barriers Fund documentation; SASSI; POPRAS; Pre and post tests for curriculum; Preconception Health Appraisals.

Major accomplishments are: Integrated into Maternity Services, entire staff trained, instrumental in obtaining more treatment centers for women and their minor children, State-Task Force on Perinatal Substance Use sponsored by State Legislators, overall entire community who serve women and children, giving priority to pregnant women and addressing issues of substance use.

6b. Has this initiative been formally evaluated? Yes, Evaluated by Department of Mental Health and Substance Abuse Services Planning and Evaluation Division.

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? This project promotes the goals of most health departments, as it relates to improving the health of status of women and children in the community. The collaboration of professionals from different disciplines is an important element in the success of your project.

7b. Has this program been replicated elsewhere? Yes

If yes, where? Four sites in Oklahoma are Lawton, Tahlequah, Tulsa, and Oklahoma City.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Douglas County Health Department
CITY/STATE: Omaha, NE

CityMatCH CONTACT: Deborah Lutjen
TELEPHONE: 402/444-7209

CONTACT FOR MORE INFORMATION: Magda G. Peck, ScD, PA, UNMC (402/559-5138)

1a. **Initiative Name:** Omaha Maternal and Child Health Needs Assessment

1b. **Category(ies) that best applies to your initiative:**
Strengthening Urban Public Health Systems - 42 Building MCH data capacity; 39 Securing urban MCH technical assistance

2. **Describe the initiative.** During FY '93 and FY '94, the Nebraska Department of Health, Maternal and Child Health Division, granted Title V funds to the University of Nebraska Medical Center to collect and analyze information on the health status of mothers and children in Douglas County. The project was designed to enhance local and state government capacity to monitor progress toward the Year 2000 Health Objectives. Valuable technical assistance to the Douglas County Health Department will enable the local health department to maintain the data collection responsibility. Reports from the project provide baseline data for MCH planning in Douglas County and serve as a template for future data reports.

The Department of Preventive and Societal Medicine and the Section on Child Health Policy in the Department of Pediatrics analyzed socioeconomic, demographic, and health data from vital statistics, census, Medicaid, hospital discharge data, and some Health Department programs. This data is an important first step toward a comprehensive assessment of the unmet health needs of women, infants, children, and adolescents in Douglas County.

Maternal and Child Health Status indicators will be linked with an inventory of maternal and child health services completed by the Douglas County Health Department. During the next year, a dissemination strategy will use the health services information and health status data to initiate community-based planning for maternal and child health.

The Omaha Maternal and Child Health Needs Assessment project represents a collaborative effort between a local health department and an academic research institution. That collaboration enabled a local health department to fulfill its core public health function in assessing MCH needs.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Douglas County Health Department provided technical assistance during the entire data analysis project. Additionally, during the second year some data analysis was completed at the Health Department. A key responsibility was facilitating community representative participation in the process.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Initially, the UNMC "Omaha Needs Assessment" project was designed to enable the Health Department to continue and build on the baseline data project. Through the dissemination of these reports, the Douglas County Health Department will be positioned as the data source for maternal and child health status indicators and information.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of a sentinel event (i.e., community MCH crisis) in the County that focused attention on MCH and development of partnerships in a comprehensive community response.

How overcome? Data analyzed in this project and other population-based data projects will be used as the sentinel event in our community. Information will be the "event" which captures the attention of the community and lead to commitments for action. Various population groups and community organizations have been included in the review and comment on the content and presentation of the data.

Barrier 2: Duplication of current or planned population-based community health needs assessment.

How overcome? The DCHD plans to collaborate with other community groups (e.g., hospitals, community-based organizations, and other data sources) to collectively disseminate data findings and collect community opinion on MCH needs and priorities. The DCHD intends to work cooperatively with other community sources in maintaining MCH health status indicators.

5. How is it funded? City/County/Local government funds; MCH block grant funds; State funds.

What is the approximate annual budget for this initiative? Title V $25,000; Other $30,000 (in-kind).

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes, objectives were process objectives which established time lines and task responsibilities during the project.

6b. Has this initiative been formally evaluated? Formal evaluation, No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Local health departments can greatly expand capacity through collaboration with existing technical resources in the community.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? The University of Illinois at Chicago, Division of Specialized Care for Children provides technical support to communities in Illinois.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Peoria City/County Health Department
CITY/STATE:	Peoria, IL
CityMatCH CONTACT:	Lise Jankowski, MS, RN
TELEPHONE:	309/679-6011

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Expanded Hours: WIC & Immunization

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 09 Breastfeeding/nutrition/WIC
Child Health - 10 Immunization
Improving Access to Care - 30 One-stop shopping, co-location of services

2. **Describe the initiative.** Clinic nurses staff immunization and WIC clinics. Numerous problems were noted in both programs including limited physical space even after extensive remodeling, increased client demand, poor immunization compliance among preschoolers and IL Department of Public Health program requests to increase the WIC caseload by 800 clients. Formal and informal program evaluations were done to assess WIC appointment showrates, immunization and WIC client requests and barriers to service.

Input was sought from staff and management. A plan was developed and implemented in November 1993. As a four (4) month pilot project we: 1) Expanded hours of service for both programs: - Immunizations are offered by appointments. Monday 7-8a, 4-5p, and all day Friday. Walk-in clinics M&W 8:30-10:30a and 1-3p, and Th 8:30-10:30a are still available. - WIC also offered earlier morning appointments, as well as appointments from 3-5p four (4) days/week. Expanded clinic from 3-4 days/week. 2) Used an early Childhood Education Center as an immunization site once/month to relieve congestion at the main office. This site is adjacent to a subsidized housing complex.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** This was a need that initiated with program staff and middle management based upon client/program needs. The Early Childhood Education Center offered space as a way to meet their students' and families' needs.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. Collaboration with the Early Childhood Education Center has opened the door for other community endeavors such as a Health Fair for school physicals.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Convincing administration to approve some radical changes in employee work hours in a unionized environment.

How overcome? All data presented was client focused, although there were definite advantages to the employees who opted to work four (4) 10 hour days.

Barrier 2: Resolving department policy questions for employees working four (4) 10 hour days with respect to Holidays: How should employee be reimbursed? For a 48 hour, 38 hour, or a 40 hour week?

How overcome? Administration discussed with the union and reached a common understanding. This was then communicated to all staff involved. Policy was revised for 10 hour/day employees.

5. How is it funded? City/County/Local government funds, Other Federal funds: Medicaid, Title XX; Private Sources: fees for immunization for non-Medicaid; Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? WIC - $333,840; Immunization - $305,000 (clinic income = fees, Medicheck, Title XX)

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. Collected data or showrates, number of individuals served, employees' requests for time off/time used, medication errors and client complaints. Improvement was seen in all parameters except appointment showrates for WIC. Major accomplishments include: 1) increasing WIC caseload from 3200 to 4100 certified clients; 2) increasing number of children immunized; 3) decreasing employees' request for time off; 4) decreasing employee sick time; and, 5) increased flexibility in meeting client requests or to offer them choices of times, day, etc. With proper advertising of changes in service hours the numbers of clients served should continue to increase.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes, very easily.

Why? It requires a management-staff team willing to problem-solve creatively and with a willingness to change programs/service delivery as necessary to meet client needs/demands.

7b. Has this program been replicated elsewhere? Don't know.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Philadelphia Health Department
CITY/STATE: Philadelphia, PA

CityMatCH CONTACT: Susan Lieberman
TELEPHONE: 215/685-6827

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** School Health Social Work Problem

1b. **Category(ies) that best applies to your initiative:**
Child Health - 17 School-linked/school-based services
Improving Access to Care - 29 Schools and health connections
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** This initiative is the product of the groundbreaking collaboration between the Office of Maternal and Child Health, Philadelphia Department of Public Health, and the School District of Philadelphia. Two social workers from the Office of Maternal and Child Health are stationed at two elementary schools in North Philadelphia, working in partnership with the school nurse to enhance the health and support services available to children from pre-school to grade 5.

The social workers have three goals: 1) to enroll every uninsured child in a health insurance program; 2) to promote good health through workshops, health fairs and presentations to teachers, parents and neighboring community organizations; and 3) to provide intensive follow-up, through letters, phone contacts and home visits, to children who have not received basic health services due to parental inattention or neglect (for example, of 66 social work referrals at one site, more than half were for vision problems that often required eyeglass prescriptions).

The schools are the Tanner Duckrey School and the Fairhill School. Both schools are comprised of low-income African American and/or Latino students with little community support and a multiplicity of poverty related disadvantages. In addition, cases of abuse and/or incest are not uncommon among the children, which requires the social workers to confront difficult psychosocial issues as well as medical and other practical challenges.

During the summer month, the social workers are stationed at community sites that mirror the population and health care needs of their assigned schools.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Office of Maternal and Child Health conceptualized this project and initiated contact with the School District of Philadelphia to plan its execution. The project was devised specifically as a way of augmenting the Office of MCH's prenatal care program with services that would attend to the pressing needs of Philadelphia's children.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. The Office of Maternal and Child Health has been recognized by administrators, teachers and parents as a proactive unit of the Philadelphia Health Department. As a result of the project's success, plans are now underway to expand to two additional schools in the next year.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Many families live under extreme stress, which prevents them from taking a more active role in maintaining their children's health. How overcome? To combat this barrier, the principal at the Fairhill School established a computer training course for parents that included as one of its requirements that parents attend all health-related presentations offered by the school. Parents who met the requirements and went on to complete the computer course have found jobs as a result of their training. Other such "incentive" programs have been effective in increasing the involvement of parents in their children's health.	Barrier 2: Collaboration between the school district and the Office of MCH has included a fair amount of "turf" wrangling. How overcome? Hands-on supervision by administrative staff has prevented the social workers from bearing the brunt of turf issues. In addition, both partner organizations have been extremely willing to respect the opinions and experience of their partner. Both organizations have kept in mind the inherent growing pains of any pilot project. Their success in overcoming this barrier has resulted in plans for the project's expansion in the next year.

5. How is it funded? MCH block grant funds.

What is the approximate annual budget for this initiative? $65,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Quarterly and annual reports to the Office of MCH indicate the success of this initiative at both sites. Data is recorded by two social workers, in partnership with the school nurse(s). Goals are set based on prior progress in meeting the project's three goals (see #2). One set of data is particularly illustrative of the project's success. Of 468 unresolved health problems at the Duckrey School, the school nurse was able to resolve 281 through phone contacts, letters, parent conferences and home visits. With the addition of the social worker, another 179 problems were resolved in similar fashion, bringing the total number of resolved problems to 460 - just eight shy of the total number reported. This result does credit to both the nurse and the social worker, and to the importance of their innovative teamwork.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? There is nothing atypical about either the setting or the staff of the Duckrey and Fairhill schools. Collaborative working arrangements can be replicated elsewhere in communities where children of low-income families need enhanced health and social services.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Maricopa County Department of Public Health Services
CITY/STATE: Phoenix, AZ

CityMatCH CONTACT: Melissa Selbst, MPH, CHES
TELEPHONE: 602/506-6066

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Bridging the Gap - Pregnancy Outreach Program

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 04 Prenatal care; 05 Expanding maternity services; 06 Home visiting; 07 Low birthweight/infant mortality
Improving Access to Care - 34 Case management/care coordination
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** To bridge the gap between Maricopa County's Correctional Health, and Public Health systems, the Pregnancy Outreach Program, Correctional Health, Inmate Services, and the Sheriff's Office developed a cooperative education, medical and referral system. The goal is to insure continuity of prenatal care as the woman moves from incarceration to open society. The Pregnancy Outreach Program identified various target groups who typically have poor birth outcomes, often leading to extensive infant stays in the newborn intensive care unit, and requiring many other special services. Pregnant women who are incarcerated at county jails and who would be released during pregnancy fit solidly into this category. With the "Bridging the Gap" program, the cooperative system begins meeting the needs of the pregnant woman while she is in the correctional system by providing program services within the correctional facility. These services include the Pregnancy Outreach Program's 12 week prenatal classes as well as individual intake and counseling sessions. Correctional Health continues to provide medical care. When a pregnant woman is released, Correctional Health notifies the Pregnancy Outreach Program so it may continue assisting the woman with her prenatal care and related health and social services that she may not have the resources to obtain. The Outreach worker follows the woman through the time of delivery, assisting her to make the transition to parenthood and offering the baby the opportunity for a healthy start in life.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Pregnancy Outreach Program initiated contact with the correctional system. Beginning a series of twelve 2 hour perinatal education classes, the POP then offered one on one counseling. The Department of Corrections became supportive of the program and began to cooperate with the POP on such issues as TB and STD screening, as well as clothing exchanges and notification of inmate release. This is the only program which links incarcerated women back into the community beginning during their jail stay and continuing after their release from prison.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The Pregnancy Outreach Program has been asked to present information on this program to various groups. This has been a visible way of meeting the needs of high risk maternity clients.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Rules and regulations of the Sheriff's Department Correctional facilities, e.g. lock-downs, scheduling conflicts, changes in food services, limited client-initiated access to the counselor.

How overcome? Lock-downs - call ahead each time. Scheduling - accommodate for both group and individual projects. Coordinate activities with times when women are scheduled in the medical facility. Changes in staff/facility - request to be informed of changes. Meet with the new officers. Changes in food service - In flux. Sometimes nutrition is adequate, with food supplements available, other times questionable. Check with medical personnel for orders. Limited client access to counselor - Accept collect calls from clients.

Barrier 2: Lack of success at securing additional funding for this program.

How overcome? Our department is committed to continue this program with a half-time counselor. To prioritize her services, she utilizes her one on one counseling sessions to assess risk factors, along with noting which clients are due for release within the near future. When clients are released, she utilizes other staff and community resources as available.

5. **How is it funded?** City/County/Local governmental funds; Private sources - Various organizations have donated baby items, food.

What is the approximate annual budget for this initiative? $16,000 for 0.5 FTE and $1,000 for education materials.

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?** Case-client forms are filled in on all clients and entered into a database. Class attendance is monitored. Progress is measured against the educational and program objectives, noting that written tests are threatening to many of these women; verbal and behavioral changes are noted, e.g.. improved fluid intake, as noted by physician, more accurate inmate records of fetal movement. Preliminary studies indicate that during 1993, less than 2% of the POP clients returned to jail. The rate of low birth weight babies was only 2%. Correctional health staff members report that, "Our patients are becoming wiser and more confident health care consumers...and they share the healthy messages with their non-pregnant roommates." Further studies are planned to look at birth weights, recidivism, job training and education on release, use of family planning, and infant immunizations.

6b. **Has this initiative been formally evaluated?** The next stage of evaluation will pull together the data listed above.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes.

Why? As long as there is rapport developed with the Corrections System, leading to a supportive relationship. There also needs to be a willingness to either use the current staff or share the cost of increased staff with the Corrections System.

7b. **Has this program been replicated elsewhere?** It a similar program exists, we would be interested in dialoguing with them.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Allegheny County Health Department
CITY/STATE:	Pittsburgh, PA
CityMatCH CONTACT:	Virginia Bowman
TELEPHONE:	412/355-5949

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Primary Care Partnerships

1b. **Category(ies) that best applies to your initiative:**
Child Health - 12 EPSDT/screenings; 13 Expanded child health services
Improving Access to Care - 25 Reducing transportation barriers; 26 Expanding private sector linkages; 30 One-stop shopping, co-location of services
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** In preparation for managed care, the Department has consolidated its well-baby clinics and is converting them to primary care centers. This is accomplished by developing partnerships with primary care providers located near our continuing clinics. Partners include a federally funded community health center and area hospitals. Models vary by community and partner.

In general, the Department brings to the partnership a caseload and staff who are experienced and skilled in serving families in their home communities. We are contributing clerical, nursing assistant and public health nursing services which are deployed to enhance primary care. This includes participating in the provision of primary care, enhancing educational services at the primary care sites, or home visiting to assess high risk families and assist in implementing the care plan developed with the family at the clinic. Our partners contribute experience in providing primary care with twenty-four-hour coverage. They bring the medical component and billing experience.

The result is expanded and less fragmented care for children and families in their own neighborhoods or nearby. WIC and dental care are among the services co-located at the primary care sites. Some sites have a variety of family support services as well.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Department approached our partners and has provided leadership in all planning activities.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** These partnerships have enhanced the Department's leadership through relationships with major primary care providers and as a result of anticipating and preparing for change in the health care system.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Effective partnerships require much hard work over a long period of time. Staff at all levels must be involved. How overcome? There is strong support for this initiative from the Director and Deputy Director. It is a priority for the Department and the Bureau.	Barrier 2: Resistance to change is usually a barrier especially for an initiative like this; some staff perceived it as a loss of direct service under our control rather than an enhancement of service. How overcome? We are still working on this barrier by repeatedly presenting the vision to staff, involving them in the planning process, discussing their concerns, and demonstrating even small successes.

5. How is it funded? City/County/Local government funds; MCH block grant funds; and Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? $275,448 is the Department's approximate contribution for the two existing centers.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Data is collected at the primary care centers and reviewed regularly by the partners. Two partnership centers are open and providing primary care for all ages. Three additional centers are currently being planned with three different partners; at least two of these will be pediatric primary care centers initially.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? This initiative should work in another community

Why? If the key elements for collaboration exist: common mission, powerful and skilled leadership, complete and uniform understanding, mutual respect and trust, true reciprocity of program ownership, sincere commitment, meaningful incentives, constant communication, and sufficient resources.

7b. Has this program been replicated elsewhere? Unknown

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	City of Portland Public Health Division
CITY/STATE:	Portland, ME
CityMatCH CONTACT:	Meredith L. Tipton, MPH
TELEPHONE:	207/874-8784

CONTACT FOR MORE INFORMATION: Layne Gregory, LMSW

1a. Initiative Name: Family Violence Collaborative

1b. Category(ies) that best applies to your initiative:
Other - Not Elsewhere Listed - 45 All other not elsewhere classified

2. **Describe the initiative.** After 6 months of intensive data gathering an invited group of 55 individuals, representing 35 diverse community providers, came together to address the issues surrounding family violence in our community.

Membership comes from the Juvenile Justice System, churces, schools, human service providers, business, media, mental health and substance abuse agencies, housing providers, recreation programs, hospital, medical community, police, legal system, shelter provider and public health. Our goal is to work toward the development of a responsive system that will lead to the elimination of family violence in our community. Action steps: 1) develop resource manual; 2) collect and analyze secondary data; 3) initiate subjective needs assessment survey among providers and present findings; 4) initiate consumer survey and present findings; 5) identify areas of common purpose based on the data; 6) define collaborative primary areas and work projects; 7) convene work groups and develop strategies, interventions and solutions; 8) develop agenda for full collaborative; 9) take steps to assure the identified system changes; and, 10) evaluate.

This collaborative addresses all aspects of family violence whether it be child, spouse or elderly. Staff began work on this collaborative in January, 1994.

3a. In planning and implementing this activity, what has been the leadership role of your health department? 1) Conceived the idea, after analyzing data that supported the need to. 2) Hired staff. 3) Consulted with all participants of the family violence system. 4) Convened collaborative. 5) Published up-to-date resource guide for system users. 6) Have become repository of current secondary data on violence.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Tremendously so! The diverse membership were unfamiliar with the "steering role" of the Health Department. The understanding and awareness of this core function is better understood than at any other time. The Health Department was applauded for this effort.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Finding the financial resources to support the effort.

How overcome? Identified cost savings from other programs and excess revenues to be dedicated to this project. This is a big area of concern from the political and city leadership.

Barrier 2: Unavailability of city specific data.

How overcome? We're working with a data guru to work the numbers for our community.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? $30,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Evaluation is based upon how well we meet our objectives as agreed upon by the entire collaborative. The objectives are all measurable and easily tracked through the workplan. Data is collected by the collaborative staff in cooperation with the members. Major accomplishments: 1) publication of a resource directory; 2) presentation of secondary data findings; and, 3) dissemination of survey for subjective assessment of providers.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Collaboratives are highly regarded as successful mechanisms that contribute to needed systems changes.

7b. Has this program been replicated elsewhere? Unknown, probably no.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Multnomah County Health Division
CITY/STATE:	Portland, OR
CityMatCH CONTACT:	Mary Lou Hennrich
TELEPHONE:	(503) 494-1827

CONTACT FOR MORE INFORMATION: Karen Lamica (503/248-3674)

1a. Initiative Name: Connections Program for Young Parents

1b. Category(ies) that best applies to your initiative:
Adolescent Health - 21 Teen parenting

2. Describe the initiative.
1. Outreach and Assessment: Community Health Nurses in hospitals, clinics, and in the field, identify teen parents prenatally, at the point of delivery, or soon thereafter, and assess their needs and refer them to the program coordinator who makes subsequent referrals as needed.
Method: CHNs visit hospitals, maternity units and work in conjuction with discharge planners to identify, assess and refer all teen mother and pregnant teens. Multi-service need clients are referred to Community-Based Agencies based on where they live. All teen parents interested in community health nursing services are referred to a field office for CHN services. Home visits, postpartum, well baby and/or developmental screening services may be provided.
2. Contracted Agency Core Services: Multi-service need teens are referred to a Community-Based Agency for core services that consist of:

a. Case Management
b. Support Groups
c. Parent Education
d. Child Development
e. Culturally Specific Services and Outreach

3. System Coordination: Coordinator tracks data on clients and facilitates cooperation between associated agencies. Ongoing program evaluation is also a component of coordination. The coordinator also facilitates cooperation between agencies, funders and ancillary services to provide smooth delivery of services. The coordinator works with case managers and their supervisors when problems arise. To ensure system efficiency on all levels, the coordinator has access to the same computer system as Community Health Nurses and case managers.

3a. In planning and implementing this activity, what has been the leadership role of your health department? We have worked collaboratively with other funders, providers and consumers to develop and implement the service delivery model.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes. Our ability to be flexible and collaborative in developing more effective teen parent services has resulted in increasing trust in our agency as a community leader. Working closely with the community in developing the initiative has also impacted our skills as leaders in gathering support, building consensus and dealing with conflict.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Implementing a completely new system and overseeing resistance to change. How overcome? Making decisions within a framework of ongoing TQI and allowing people time to adjust to the changes.	Barrier 2: Dealing with the time it has taken to implement the computerized training system. How overcome? Patience and preparing as much as we can.

5. How is it funded? City/County/Local government funds.

What is the approximate annual budget for this initiative? 2.0 CHN, .5 PDS, $360,000 for service

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?

1. Yes
2. The CHNs and Community-Based Agencies we contract with collect the data.
3. Creating and implementing the initial intake form.
4. Surpassing our original goal of visiting at least 70% of teen parents in the hospital.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? We have overcome the barriers associated in dealing with a diverse group of providers and are beginning to reap the rewards (e.g., earlier intervention) of having providers of care collaborate with each other.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Wake County Department of Health
CITY/STATE:	Raleigh, NC
CityMatCH CONTACT:	Peter Morris, MD, MPH
TELEPHONE:	919/250/4637

CONTACT FOR MORE INFORMATION: Julia Smith (919/250/4637)

1a. **Initiative Name:** Hospital Alliance for School Health

1b. **Category(ies) that best apply to your initiative:**
Adolescent Health - 18 School-linked/school-based services
Improving Access to Care - 29 Schools and health connections; 34 Case management/care coordination

2. **Describe the initiative.** The Hospital Alliance for School Health is a community funded and focused pilot program serving four elementary, one middle and one high school in inner city, Southeast Raleigh. Privately funded by the County's three local hospitals, the Alliance provides services to improve school performance and success of students in the targeted schools.

Four school nurses are assigned one or two schools each, providing screening, referrals, consulting, and counseling to students, families and faculty. A school linked clinic, staffed by a clerk, nurse, and PA with physician consultation, provides clinical assessments. Nurses use case management skills for students or families requiring on going care, referring the most difficult cases to a full-time social worker. A part-time nutritionist counsels parents, teachers, and students and coordinates health fairs. Each school chose and implemented a health promotion initiative.

Prior to the Alliance expansion, eleven school nurses were spread thin serving almost 80,000 students in 94 schools. The alliance pilot program aims to prove the benefits of intensified school health intervention.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Director serves as the President of the Hospital Alliance for community health, a 501(c)(3) corporation whose Board members represent the CEO's, Boards, and physician staff of three area hospitals. The Alliance board chose to fund this project from among a dozen proposed by the Department of Health staff.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Absolutely. The Department of Health by demonstrating initiative, planning and management is more highly regarded by private business and physicians in the community, and is credited with bringing private support to a community problem.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Redirecting efforts of school health nurses. How overcome? The purpose of the Alliance is to improve school performance, not simply increase access to health services. Nurses must consider which interventions will best improve grades, promotion, and graduation. Team meetings, workshops, evaluation, and redirection occurred monthly.	Barrier 2: Redefining school health to the schools. How overcome? The Alliance does not staff sick rooms. Faculty meetings, one on one sessions with administrators and teachers, and constant reminders that school success was the focus - not distribution of tylenol - kept the schools on track.

5. **How is it funded?** Private source(s): Private, nonprofit formed by area hospitals. Third party reimbursement (Medicaid, insurance).

What is the approximate annual budget for this initiative? $370,000/year (over $1 million committed over 3 years)

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date?** Both process and outcome data are collected to assess service delivery and school performance. Service data is collected per State requirements, with local and project modifications. School success is measured by changes in absenteeism, end of year grades, promotion rates, drop out rates, etc., provided by the schools.

Over 45% of students were served year one; nearly 200 were case managed. Parent and teacher surveys noted improved grades and decreased absenteeism among students served. Formal statistical analysis of grades, promotions, etc. is underway.

6b. **Has this initiative been formally evaluated?** Yes

7a. **Do you think that this initiative would work if implemented in another urban community?** Possibly.

Why? Every community needs to invent school health programs and services acceptable to that community. For some communities, this is school based clinics; for other communities, this is sick rooms. For Wake County, it means services to improve school performance.

7b. **Has this program been replicated elsewhere?** No

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Monroe County Health Department
CITY/STATE: Rochester, NY

CityMatCH CONTACT: Karin Duncan
TELEPHONE: 716/274-6192

CONTACT FOR MORE INFORMATION: Patricia Sood

1a. **Initiative Name:** Breastfeeding Promotion Plan

1b. **Category(ies) that best applies to your initiative:**
Prenatal Health - 09 Breastfeeding/nutrition/WIC

2. **Describe the initiative.** The purpose of this project is to increase the incidence and duration of breastfeeding among WIC participants. Our local agency is working to increase breastfeeding rates at hospital discharge from 28.6% to 35% by December 31, 1994. We would also like to increase the number of infants breastfed longer than eight weeks from 20.5% to 25% by December 31, 1994. We have identified and recruited approximately 150 WIC clients interested in applying for training as breastfeeding peer counselors. We have to date conducted two eight-week training sessions in breastfeeding management to prepare these volunteers for breastfeeding promotion and support activities at various locations throughout Monroe County. As of June 25, we will have trained 25 peer counselors. We are following a caseload of approximately 70 WIC prenatal clients, and our goal is to expand that to approximately 250 clients by the end of October, 1994. We currently have about 1700 women on the Monroe County WIC Program. So these 250 clients represent about 15 percent of our prenatal caseload. We are noticing an increase in the number of teenagers and young adults breastfeeding successfully as we initiate outreach efforts with Healthy Moms, Young Mothers, and Threshold.

Our breastfeeding promotion plan consists of three contacts with a breast-feeding mom prior to delivery with an option for her to attend a breastfeeding class prenatally if she desires.

Breastfeeding women have four contacts in the postpartum period. These contacts are for encouragement, problem solving and education.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** In planning and implementing this activity, the Monroe County Health Department WIC Program has been networking with many health care providers and community agencies to provide experts in all areas of breastfeeding management for training of peer counselors and to identify community resources to ensure breastfeeding success for our WIC clients.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the HD has been enhanced as a result of this activity because it has been an opportunity for myself, as a professional, to both learn more about breastfeeding and find out what resources are actually available within our community.

There is plenty of opportunity in this position to be creative and try several approaches to problem solving to arrive at the desired agency goal.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Difficulty motivating Peer Counselors and keeping their interest once trained.

How overcome? Developing creative projects for them to work on. Having monthly meetings which provide continuing education for them. Writing grants to provide motivational incentives.

Barrier 2: Time has been a limiting factor (adequate time to meet the demands and education of Peer Counselors and clients).

How overcome? Using time management skills: setting priorities, delegating responsibilities to others when possible. Using organizational skills to help the work flow. I am constantly reviewing and revising.

5. How is it funded? Other: New York State Health Department funds.

What is the approximate annual budget for this initiative? $60,000.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? We will be able to determine when agency goals have been met by reviewing computer-generated reports from the New York State Department of Health at the end of December. These reports will tell us the number of postpartum women breastfeeding at hospital discharge and length of breastfeeding in weeks.

6b. Has this initiative been formally evaluated? No, not at this time.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Because breastfeeding moms usually recognize the need and are interested in helping other moms learn to breastfeed.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Several projects within New York State and in other states also.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Marion County Health Department
CITY/STATE:	Salem, OR
CityMatCH CONTACT:	Donalda Dodson
TELEPHONE:	503/585-4977

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** North County Consortium

1b. **Category(ies) that best apply to your initiative:**
Prenatal Health - 04 Prenatal care
Child Health - 13 Expanded child health services
Other Outreach - 23.3 Adult education
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships
Other - Not Elsewhere Listed - 45

2. **Describe the initiative.** Provides comprehensive and coordinated prenatal care to 100 low income pregnant women, parenting education to 40 families, well-child care to 100-200 children and comprehensive health service advocacy to the enrolled families through a four-agency consortium. Emphasis is one reaching low income women in the Latino community. The emphasis is on improving and promoting easy access and comprehensiveness of service through a systematic provider approach, making a "community system," through a consortium. Efforts continue to cultivate, enlarging the consortium and increasing collaborative partnerships to include more community agencies and groups.

Services are provided on a sliding fee scale with no one denied service if unable to pay. The focus is on the pregnant/post partum women and her children age three years and younger, yet realizing the entire family dynamics and needs impact that woman and her child. Outreach is available to assist clients' access to health and supplemental services as indicated. Extensive teaching is offered to assist clients in skills building so they can then access resources as they graduate.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Health Department brought community players together to discuss the collaborative consortium service model and then took the lead in writing and development of the proposal. The Health Department continues to facilitate ongoing consortium planning, evaluation, and service meetings and as issues present, the Health Department negotiates the consortium resolution.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The Health Department leadership credibility has been enhanced, the Health Department is looked to for leadership and for assistance in influencing decision makers to look favorably on this project and other areas within the community as well.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Keeping a collaborative consortium alive with good participation. How overcome? Frequent dialogue and meetings. Keep the channels of thought and communication open. Discuss issues until resolved.	Barrier 2: Retaining qualified bilingual, bicultural staff. How overcome? Rearrange staff from within the Department; recruit from within.

5. How is it funded? General state funds.

What is the approximate annual budget for this initiative? $132,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? ☐ Yes.

1) One hundred women will receive prenatal care early in pregnancy to six weeks post partum.
2) One hundred women will have a service plan developed to assure attention to their comprehensive needs, the plan being reviewed periodically at the provider's regular meeting.
3) One hundred children will receive well child physical assessment and follow-up following the accepted periodicity schedule.
4) Forty families will attend parenting sessions of 10 weeks each.

Data is collected using two information specific forms and entered into data system. Accomplishments: 100 women services and over 150 children seen and 40 families received parenting.

6b. Has this initiative been formally evaluated? Yes

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Collaborative partner-shipping enhances services available and develops a stronger, more comprehensive service system for the client.

7b. Has this program been replicated elsewhere? No

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Salt Lake City, County Health Department
CITY/STATE: Salt Lake City, UT

CityMatCH CONTACT: Suzanne Kirkham
TELEPHONE: 801/468-2726

CONTACT FOR MORE INFORMATION:

1a. Initiative Name:

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 04 Prenatal care, 05 Expanding maternity services
Child Health - 13 Expanded child health services
Improving Access to Care - 26 Expanding private sector linkages; 30 One-stop shopping, co-location of services; 35 Increasing access to Medicaid

2. **Describe the initiative.** To increase prenatal services, provide a bridge between prenatal and well child services and increase well child services, a contractual agreement has been entered into with the University of Utah Departments of OB-GYN and Pediatrics.

This agreement provides a OB attending and two residents three half days a week and a pediatric attending and two residents five days a week. These providers work along side our nurse practitioners to provide care to women and children.

The hope is to bring a stronger university presence into a health department clinic. Provide 24 hour coverage which we now lack and provide trainings for residents. This allows the nurse practitioners to benefit from more consultation on site. The ability to see more complicated women and children exists. Other services such as WIC, immunizations, an EPSDT outreach worker and a medicaid eligibility worker are available to families. The transition from prenatal to well child care happens under one roof.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The leadership role could be debated. The state Health Department pulled everyone together in the beginning. The original players also included community health centers who have also attempted to co-locate with the University.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. We have strengthened community ties and developed new working relationships.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Financial - how to finance the project adequately. How overcome? Haven't yet.	Barrier 2: Meshing different philosophies such as services need to be provided regardless of ability to pay. How overcome? Haven't yet.

5. How is it funded? City/County/Local government funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance); University Funding.

What is the approximate annual budget for this initiative? Not sure at this point.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? We began formally in July - one objective is to try to fund all of those activities. Data collection will be mostly financially based initially.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?

Why? It can work as long as a strong commitment exists on all parties to provide services to underserved populations.

7b. Has this program been replicated elsewhere? Don't know.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	County of San Diego Health Department
CITY/STATE:	San Diego, CA
CityMatCH CONTACT:	Nancy Bowen
TELEPHONE:	619/692-8808

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** Building Healthier Futures, Communities in Action for Children, Youth and Families

1b. **Category(ies) that best applies to your initiative:**
Strengthening Urban Public Health Systems - 37 Strategic planning for urban MCH

2. **Describe the initiative.** The Vision of "Building Healthier Futures: A community of children, youth and their families who are healthy in body, mind and spirit." This plan is an innovative, county-wide effort to plan for and address the priority health needs of San Diego's communities. It was developed through an intensive, year-long planning process that involved our 300 public, community-based and business organizations as well as direct input from youth and families. Five major agencies representing the concerns of San Diego's children, youth and families sponsor the Strategic Plan: these include the Child Abuse Prevention Foundation, Children's Initiative, County of San Diego, San Diego Health Coalition for Children and Youth and the San Diego and Imperial Counties Regional Perinatal System.

   In keeping with our Vision, the Plan defines health in the broadest possible sense. It encompasses, for example, not only freedom from illness but also living in a safe and supportive neighborhood and possessing the reading and writing skills to complete school or obtain a job. Hence, the Plan is organized around eighteen major issues ranging from the prevention of tuberculosis to the promotion of family friendly business policies. Several Priority Actions are proposed for each Issue. Together, these Priority Actions represent a prevention-oriented and coordinated approach for addressing the Issues.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** We initiated the process and were instrumental to bringing on the other (private sector) partners. We have supplied (primarily through our Title V funds) most of the resources for staffing and facilitating the planning process.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes. Many people have been discussing the need for: a) public/private partnerships; b) integration/collaboration; and c) government doing assessment, assurance and policy development. These needs have been addressed to a significant degree in a very tangible, reputable manner. The support for the process is very substantial and the critical role the Health Department has played is recognized.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: The perception if Government is involved in such a process, it will "take over" and the private sector will not be a full "partner."

How overcome? Very careful to appoint "non-Government" people to almost all leadership positions and County personnel have more "Staff support roles." Most decisions/work product come from the community and county staff could "edit" but not change the content. This concern was continually discussed and addressed in an open manner.

Barrier 2: This "health" initiative encompasses many social service, law enforcement, economic issues and yet the majority of participants are from the health sector.

How overcome? a) We are broadening the participation. b) We are facilitating the "ownership" of this initiative by a couple of key collaboratives (one in County government and one external) that span all the sectors. (One of our five sponsors, Children's Initiative, is the external collaborative.)

5. How is it funded? City/County/Local government funds; MCH block grant funds.

What is the approximate annual budget for this initiative? $100,000/year.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. Data is collected from Vital Records and several other sources. This will be revised semi-annually. Implementation of specific "Priority Actions" by those committed to them will be followed/coordinated by Action Coordinators as well and the status of implementation will be communicated to the community at large. Final draft of the Plan has been written (printed by November). Initial implementation on Actions has begun. Our "official" unveiling of the initiative is being arranged for the Fall.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This essentially carries out the assessment, planning, and policy development Public Health roles that have been agreed upon. (The assurance role is presently a smaller "piece" thus far.) This is done through a Strategic Plan model meeting a "Community organization" model.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Santa Clara (CO) Valley Health and Hospital System Public Health Department/MCAH Division
CITY/STATE:	San Jose, CA
CityMatCH CONTACT:	Julie Grisham, MCAH Director
TELEPHONE:	408/299-5036

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** MCAH Community-Wide Strategic Planning Process

1b. **Category(ies) that best apply to your initiative:**
Strengthening Urban Public Health Systems - 37 Strategic planning for urban MCH

2. **Describe the initiative.** In February 1994, the MCAH division of the Public Health Department was selected to be one of three pilot counties in California to receive the Family Health Outcomes Project technical assistance package. The project is providing technical assistance in MCAH quantitative needs assessment and the development of health status/outcomes indicators for public health monitoring and program design and evaluation. In May 1994, a private consultant firm specializing in Strategic Planning was contracted to work with the MCAH Director to design a plan for implementing a community-wide strategic planning process for MCAH in Santa Clara County. These two efforts were combined, and through a collaborative process with MCAH providers within the Santa Clara Valley Health and Hospital System (includes Public Health, Mental Health, Alcohol/Drug Abuse, Ambulatory Care/Primary Care, and the Hospital), a planning process was developed. The scope of the plan will be two tiered. The first tier will address the range of issues traditionally included under MCAH such as infant morbidity/mortality, teen pregnancy, immunization etc. The second tier of the plan's scope will focus on those issues which affect MCAH but are outside the capacity of public and private MCAH providers in coordination with MCAH. Some examples of these are homelessness, poverty, and racism.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The MCAH Director submitted the proposal to obtain the technical assistance package from the Family Health Outcomes Project. In collaboration with top officials and the Data Manager, she also contracted with the Strategic firm and has been active in facilitating the process. There are still many details and political implications to work out, and the MCAH Director and key MCAH managers and staff will provide leadership to the community to promote a truly collaborative MCAH Strategic Plan.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership of the Public Health Department has been enhanced by; the formation of the MCAH coordinating Council with all MCAH providers within the Valley Health and Hospital System; the ongoing collaboration, leadership, and/or staffing of most of the major MCAH Community groups and networks in Santa Clara County ; and by the commitment of the top leadership within the Board of Supervisors, within the Health System and in the community to address MCAH issues.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of coordination and/or focus of the community in addressing MCAH issues as a whole. There are many MCAH community groups, networks, collaborative, advisory committees, task forces etc. with no acknowledged coordinating body looking at or being able to speak for MACH issues community wide. The result is a great deal of well meaning efforts that are fragmented and sometimes duplicative.

How overcome? We are currently in the process of addressing this barrier. There have been internal meetings to address combining some of the perinatal groups. The next step is the consultant, the PH Director and the MCAH Director meeting with leadership from current large MCAH coordinating groups to dialogue and determine whether to enhance or combine for implementation the MCAH strategic planning process.

Barrier 2: The perception by MCAH leaders, public and private, that there has already been a great deal of MCAH planning in Santa Clara County and that people are tired of planning and want action.

How overcome? When either the consultant or MCAH director meet with top officials, MCAH public and private providers, and community groups, we begin by acknowledging that Santa Clara County is a sophisticated and knowledgeable County in terms of defining MCAH issues. We also acknowledge the commitment and excellence of the services that are currently being provided to MCAH vulnerable populations. We then promote "buy in" by sharing data and health outcome indicators to support the prioritization of issues and assure that a "strategic plan" involves action plans and follow up to obtain funding and implement programs that address the issues. Overcoming this barrier will be an ongoing process.

5. How is it funded? City/County/Local government funds, Other: State Dept of Health. Services

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? The planning process has specific objectives which involve: 1) Defining the scope of the plan; 2) Planning for and implementing community involvement/input; 3) Defining and implementing the structure of the process; 4) Utilizing Data for determining priorities and ongoing evaluation; 5) Utilizing the MCAH year 2000 objectives.

Have defined the planning process. Have "buy in" from many public and private agencies in the Health System and Community. Have defined many of the MCAH data indicators/health outcomes that are most crucial to address in Santa Clara County.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? because planning for the coordination and development of MCAH services in many urban communities has similarities in terms of complexity, data and assessment needs, structure/process needs, "buy in" and internal and political support, evaluation, funding, setting of priority issues and exploring implementation of programs to address the issues, to name a few.

7b. Has this program been replicated elsewhere? San Diego County developed a MCAH Plan that encompasses similar areas to our plan. The vision for the Santa Clara County Strategic Plan, will rely more heavily on data health indicators/health outcomes and action plans/funding projects to meet priorities. There may be other MCAH strategic plans in other health jurisdictions in the United States of which we are not aware.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	San Juan Health Department
CITY/STATE:	San Juan, Puerto Rico
CityMatCH CONTACT:	Dr. Magda Torres
TELEPHONE:	809/751-6975

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** No Barriers To Immunization - San Juan 2000

1b. **Category(ies) that best apply to your initiative:**
Child Health - 10 Immunization

2. **Describe the initiative.** One of the efforts of the Municipality of San Juan is to achieve the goal that by year 2000, 90% of children are adequately immunized by age 2. To this effect and following federal guidelines we developed a series of meeting and coordination with different representatives of public and private sectors, agencies and institutions of our community, to form a partnership and submit a proposal.

In 1992 the San Juan Health Department, submitted an IAP proposal requesting funds to help improve immunization programs and implement new initiative that could help achieve our goal. As a result an action plan (Infant Immunization Initiative - San Juan 2000) was elaborated based on the problem and needs assessment of our community.

Immunization services hours were expanded in each of our nine Diagnostic and Treatment Centers from 7:00 a.m. to 3:00 p.m. Extended hour immunization services were open on 1993. It operates from 5:00 p.m. to 8:00 p.m. (weekdays) at one DTC per week and from 8:00 a.m. to 12:00 noon on Saturdays at 2 DTC's (addendum 1). Also in February 1993, five (5) Satellite Immunization Clinic's were open at CBO's high risk areas for vaccine delinquency on San Juan.

A mobile unit team devotes 50% of their time to these CBO's Satellite Clinics and special immunization activities at different areas of San Juan. Plan emphasizes mainly on the removal of barriers, increased services, education and orientation.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** Our Health Department has acted as coordinator and leader in the joint effort between the public and private sector. Meetings were done at our facilities, and barriers and problems related to immunization services were identified and corrective solutions were suggested. Also CBO's interested in offering their facilities to establish Satellite Clinics signed as agreement. Our new plan initiated by January 1993 and federal funds were given by March 1993 ($82,181) which help part of the activities needing funds.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** Yes, this initiative has permitted different public and private sectors to get a better view of the work done at San Juan City Health Department, Maternal and Child Division. It has also enhanced their input and cooperation to the immunization activities for the different sectors of San Juan.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Financial funds needed and requested for new personnel to meet the goal weren't granted.

How overcome? These objectives were reset and the limited resources were adequately distributed to improve the existing services and open extended hours Immunization Services.

Utilization of S.J.H.D. existing personnel was done for these efforts. Incentive bonuses for the increasing functions were given which otherwise required an increase in salaries. This is more cost effective.

Barrier 2: Patient's safety: patients are reluctant to attend the extended hour services for vaccination due to the high criminality rate at night hours.

How overcome? For the moment the security of each DTC is being improved (more watchman, bullet proof doors). Problems are not yet totally overcome.

5. How is it funded? City/County/Local government funds, Other Federal funds.

What is the approximate annual budget for this initiative? An approximate of $3 million.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What are the major accomplishments to date? Yes. We had determined that DPT-4 (the four doses of DPT) administered to children below two years be our measurable outcome objective. Data is gathered by the statistic office and evaluated periodically by our office. For the first year of our project we achieved and surpassed our outcome objective. Our outcome objective 1994 was 2,886 doses of DPT-4 (addendum 2). By the end of December 1993, we had administered 3,223 doses of DPT-4 to children below 2 years of age (addendum 3). Also, an adequate system was coordinated with private hospital and physicians office for referral to our services for those who cannot afford vaccines.

6b. Has this initiative been formally evaluated?

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Because it offers options to clients who can't go to our regular immunization clinic either because of distance or working schedule. Up to December 1993 (Project 1st year) 3,731 doses of all vaccines were administered at extended hour services and 1,364 at CBO's clinics. (Addendum 4 and 5)

7b. Has this program been replicated elsewhere? No

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Orange County Health Care Agency
CITY/STATE:	Santa Ana, CA
CityMatCH CONTACT:	Len Foster
TELEPHONE:	714/834-3882

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Perinatal Substance Abuse Services Initiative

1b. Category(ies) that best applies to your initiative:
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. Faced with the growing realization that perinatal substance abuse represents a significant health problem within the Orange County community; that women of childbearing age who abuse alcohol and other drugs have either limited access to medical care or are not motivated to seek medical care; that pregnant substance abusing women represent the single greatest risk for adverse birth outcome, the county health officer initiated an interagency task force to examine the problem and formulate solutions.

The result was the Perinatal Substance Abuse Services Initiative, which is designed to provide intake, assessment, case management and coordination, and monitoring/evaluation services in support of substance abusing women, particularly those who are pregnant. Services are provided by public health nurses. The Initiative was created by a Task Force representing the County's alcohol, drug abuse, MCH, HIV/STD, public health nursing, and social services agency management. It also included a private not for profit, perinatal case management organization.

The Initiative provides case management of clients in a unique manner, inasmuch as they "fill in the gaps" of client support and case coordination when clients are known to more than one service organization. Specifically, the Initiative staff address the issue of medical care for clients enrolled in substance abuse treatment programs, and provide the liaison between the medical care provider and the substance abuse treatment provider. Initiative staff work with community outreach staff associated with the social services agency to link identified substance abusing women with drug treatment programs, medical care providers and other resources. In essence, Initiative staff view the client in totality, rather than limiting their activities to a specific portion of the client's needs. Additionally, Initiative staff assist in the training of medical providers to understand the unique needs of those high risk clients so that they are better able to retain them under care. By so doing, both community capacity is increased and birth outcomes improved.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The county health officer was the official who initiated the process leading to the development of the Perinatal Substance Abuse Services Initiative. He appointed, or caused to be appointed, the members of the Task Force, and was vested with the ongoing responsibility for operation of the Initiative.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? The health department's leadership position has been enhanced both within the county family and the community. Through this process, other county agencies, particularly drug and alcohol treatment programs and the social services agency, developed an improved understanding of the value of public health staff in collaborative settings. Private obstetrical providers have learned of the value of public health staff in supporting their efforts by extending case coordination to their clients. This acknowledgment may be of greater importance within the context of a managed care environment.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Organizational jealousies and issues of turf that lead to concerns about control of the Initiative and resources.

How overcome? All county organizations involved in the provision of related services to substance abusing women were given equal representation on a policy steering committee which provided oversight during the design process. Additional representation from all operating units was provided on a technical coordination committee, which was responsible for the development of system design, process flow, and the resources requirements. All decisions were based on consensus, and while there was a position of chair (a public health representative), the chair functioned more in the role of facilitator. This process built trust and facilitated share ownership of the Initiative.

Barrier 2: Funding of a new project at a time when budget restrictions impacted all county agencies and departments.

How overcome? Building upon the shared ownership of the Initiative, a formula was developed to allow the cost of the Initiative to be shared among the major players. While a substantial portion of the cost was absorbed by public health with the support of Tobacco Tax revenues, the drug and alcohol programs share the cost of one support position, and the social services agency absorbed the cost of space, equipment and overhead.

5. How is it funded? Tobacco Tax revenues, Drug and Alcohol Program funds, Social Service Agency funds.

What is the approximate annual budget for this initiative? $242,776

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Outcome objectives have been developed. They relate primarily to the success in gaining access for pregnant, substance abusing women into substance abuse treatment and prenatal care; their continuation under care through six months post partum; and the results of toxicology testing at delivery. Data is collected manually by Initiative staff via access to client records granted through a signed, multi-agency patient consent form. Preliminary data is quite promising. However, the numbers are too small, and the process is too new to be meaningful at this time.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? The principles of coordination of care are consistent regardless of the community. The Initiative described merely represents a system of augmenting existing program staffing and case coordination efforts with an overlay which is designed to fill in the gaps which would otherwise result. Such a model could readily be modified to correspond to the needs of another community.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	County of Sonoma Department of Health Services
CITY/STATE:	Santa Rosa, CA
CityMatCH CONTACT:	George R. Flores, MD, MPH
TELEPHONE:	707/576-4700

CONTACT FOR MORE INFORMATION: Norma Ellis, Director of Nursing (707/576-4731)

1a. Initiative Name: Sonoma County Maternal Child Health (MCH) Strategic Planning

1b. Category(ies) that best applies to your initiative:
Strengthening Urban Public Health Systems - 37 Strategic planning for urban MCH

2. Describe the initiative. In February 1994 the Sonoma County MCAH team attended a state conference on public health leadership and community-based planning strategies around MCAH populations. Upon returning to the county, the core team used this information to co-sponsor, with the local MCAH Council, a community-based, two half-day planning event regarding the major problems and solutions for MCAH target populations. Over 80 participants were invited (public and private agencies and clients) with a goal of about 50 attendees. Participants were provided with a 30 page document, prior to the meeting, which included local and state MCAH health indicators. A key note speaker began the meetings by urging participants to include political, social and economic issues, which impact the health of the population when they were considering problems, issues and solutions. Participants were assigned to one of four groups based on their agency's background, which were either maternal, infant/toddler, school-age or adolescent health. Each group had a facilitator and documenter, who used a very directive and structured process called IHES. Each group was to define the key health problems, causes of the problems and solutions for their target groups. Following the meetings, the results were analyzed and provided back to the participants in a formal report as follows:
Maternal Population: primary health problem is the breakdown of the primary support system of family and community chased by poor economics and ineffective programs. Solutions included improved collaboration between existing programs. Infant/Toddler: Primary health problem was lack of community involvement and participation of parents caused by a lack of sense of community or connectiveness in neighborhoods. Solutions were to establish a sense of community by holding small community meetings focusing on known problems to achieve community empowerment. School Age: Primary health problem was poor access to care caused by inadequate funding of services and low fee reimbursement for providers. Solutions were to shift existing funding to meet prioritized needs. Adolescent: Primary health problem was a lack of role models for teens, lack of parental guidance and overall lack of attention to their needs caused by no clear definition or expectations around good parenting or awareness of obligations. Solutions were creating and promoting definitions of good parenting and parenting education at all levels and opportunities throughout school.

Also included were suggestions for future actions for agencies and the health department and a survey to evaluate the planning event and the report. As a thank you, all participants were also provided a health department report called Health Profile'94: The Health of Our Community with a variety of health indicators on the overall community.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The health department role was to identify that this event was important to the community, to plan, invite and hold the planning sessions and to report back to the participants about the findings and potential future plans.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Many participants remarked that this planning was important and that they were pleased that the health department took the initiative to set it up. Follow-up activities by the health department will be imperative to continue the momentum and the positive image that was set by this initiative.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Choosing a tool for the planning sessions.

How overcome? Choosing a tool, which would be easy to understand and implement, for taking the groups through the initial planning phase was somewhat of a barrier. The core team reviewed several tools taught in the Leadership Workshop such as the nominal process, Delphi, etc. Other tools already known to the group were also reviewed. The IHES (Insuring Health Environments in Schools) was chosen because it was very structured and directive and built on three concepts (brainstorming, advocacy and prioritizing) which built group consensus. Upon evaluation 100% of participants felt that the process always or usually resulted on group consensus.

Barrier 2: Communication between participants whose focus and agendas were somewhat diverse.

How overcome? While the diversity made communication between participants difficult, it also served to expand the understanding of the key problems that were identified and helped address what role economics, politics, etc. played in impacting the health issues identified for target populations. These differences were simply acknowledged and incorporated into the report.

5. How is it funded? MCH block grant funds; March of Dimes and Health Plan of the Redwoods each contributed funds to cover lunches and continental breakfast for 55 participants.

What is the approximate annual budget for this initiative? $8,130

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The primary objective was to hold an event co-sponsored between the Health Department and the local MCAH Council in order to provide community-based planning for the health of the MCAH population.

6b. Has this initiative been formally evaluated? Based on the evaluations turned in by participants, 94% felt that the MCAH issues, causes of issues and potential solutions were very pertinent or somewhat pertinent to the MCAH target population.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? This would be (and has been) successful in another urban community because it sets up a workable forum for groups to meet, exchange ideas and plan, using group consensus, regarding the important issues within their community.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? In other California counties.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Seattle-King County Health Department
CITY/STATE: Seattle, WA

CityMatCH CONTACT: Kathy Carson
TELEPHONE: 206/296-4677

CONTACT FOR MORE INFORMATION: Cathy Gaylord

1a. **Initiative Name:** Expanded School Intervention Team Project

1b. **Category(ies) that best applies to your initiative:**
Child Health - 17 School-linked/school-based services

2. **Describe the initiative.** The "Expanded SIT" Project adds community-based agency representatives to existing school interventions teams (SITS) and gives the teams access to flexible funds to purchase for children and families health and social service items and services that are unavailable through existing programs. The Expanded SIT model was selected for implementation under the Robert Wood Johnson Foundation Seattle Child Health Initiative (based at Seattle-King County Health Department) because it offered a mechanism for improved service integration and smoother service coordination and was suitable for testing the concept of a flexible fund. Three schools established Expanded SITs under the Child Health Initiative during the 1993-1994 school year. After the state-funded Readiness to Learn Project (administered by the Seattle Department of Housing and Human Services) also opted for the Expanded SIT model, an additional 3 schools joined the Expanded SIT Project. This project operates as a collaboration between Child Health Initiative and Readiness to Learn.

The participating schools selected community-based agency representatives from public-health, mental health, child welfare, social services, and family support agencies. Community-based representatives attend the school SIT meetings on a regular basis, participating in the staffings and assisting in deliberations over where resources might be found to meet needs and whether it is necessary to tap the flexible fund. The parent is included as a member of the team staffing their child, building on family strengths and responding to needs with individualized services.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** As the RWJ grantee, the Health Department brought together the community advisory board that conceived the project. The grant funded coordinator negotiated with RWJ to accept the advisory board's plan, identified community agencies willing to commit staff time, and devised the mechanisms for operation of the flexible fund. She also collaborated with the writers of the Readiness to Learn grant to adopt the same model so that additional sites could be funded.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The project has added to the Health Department's experience in collaborative projects and has increased our credibility with school personnel.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Medicaid Managed Care

How overcome? Expanded SITs can assist families to access care in a managed care system, but school-based service delivery, especially EPSDT which can be a gateway to other services, is no longer feasible. The seven managed care plans serving the county will not authorize school-based services.

Barrier 2: Community agency staffing limitations.

How overcome? Still somewhat of a problem, but experience has shown them the value of being involved. Expansion to other schools will be difficult if additional resources cannot be found.

5. How is it funded? General state funds; Private sources - RWJ Foundation; and Other - Medicaid Administrative Match.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? A formal evaluation is being developed in conjunction with Readiness to Learn. Data is being collected on the number of students staffed, their needs, and how their needs were met. The major accomplishments to date have included the extension of the project using a state Readiness to Learn grant and the enthusiastic support for the project that is expressed by staff from each of the schools involved.

6b. Has this initiative been formally evaluated? No, (by 6/95)

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? Because the model is designed to use existing community resources to target the individual needs of children and families, it is likely to be successful anywhere.

7b. Has this program been replicated elsewhere? Not Known

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Spokane County Health District
CITY/STATE: Spokane, WA

CityMatCH CONTACT: Barbara Feyh
TELEPHONE: 509/324-1617

CONTACT FOR MORE INFORMATION: Lisa Ross

1a. Initiative Name: Parents and Professionals Activating Coordinated Care and Transitions.

1b. Category(ies) that best applies to your initiative:
Women's Health - 01 Preconception health promotion
Prenatal Health - 06 Home visiting

2. Describe the initiative. Children with Special Health Care Needs Special Project. One stop shopping is available through the on-site provision of special education, physical, occupational and communication therapies, pediatric evaluations, nutritional consultations, orthopedic evaluations, case management services, parent to parent linkages, counseling services and parent support groups.

The project will add case management, public health nurse home visiting and psychosocial services to the therapy and medical services currently provided young children with special health care needs in Spokane, WA. Public health nurse home visiting, social work counseling and parent to parent support groups add to the one-stop shopping within a community-based early intervention center. The project merges the private, non-profit and public agency personnel to improve access to appropriate services, decreases fragmentation of services, and modeling, the fragile and critical point where families begin services for their special needs infant, the project strives to empower families to eventually become their own case manager.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The Health District originated the idea for the project and worked with our local neuromuscular center to write the grant. The neuromuscular center is the grantee who then subcontracts with the Health District.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Yes. Spokane County health District has been providing service to special needs children and their families for years. The addition of this project has increased community awareness of the Health District's role with this special population.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: The project experienced a 45-day delay in hiring the public health nurses. Drafting the legal inter-agency contract and filling the positions in accordance with state and federal hiring mandates contributed to this delay.

How overcome? The project has been able to hire all necessary staff and complete training requirements.

Barrier 2:

How overcome?

5. How is it funded? Other Federal funds - CISS; Non-Federal match.

What is the approximate annual budget for this initiative? $177,900

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Yes. The project has yet to complete its first year.

The project will be evaluated on the basis of its measurable objectives, summary time table, parental satisfaction surveys and budget compliance. This information will be reviewed bi-monthly by a committee comprised of the project director, public health nurse supervisor, developmental center executive director and the chairperson of the Program Enhancement Committee from the developmental center's Board of Directors.

In accordance with the Washington State MCH needs assessment goal to develop a system for statewide data collection and analysis, both the local Spokane County Office of Children with Special Health Care Needs and Spokane Guilds' School have accepted initial contract monies for computer systems and software.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? The project intermingles the personnel and knowledge resource base of the private non-profit sector and the public health district. This networking exponentially enhances information and service delivery to families of young children with special health care needs.

Every community has the capacity to "marry" the private non-private sector with public health.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: St Paul Public Health Department
CITY/STATE: St Paul, MN

CityMatCH CONTACT: Diane Holmgren
TELEPHONE: 612/292-7712

CONTACT FOR MORE INFORMATION: Anne Kuettel

1a. Initiative Name: Children's Immunization Project

1b. Category(ies) that best applies to your initiative:
Child Health - 10 Immunization
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. Describe the initiative. The Children's Immunization Project is a public/private partnership of many agencies which provide immunizations and related services to area residents, primarily focusing on the Saint Paul community.

The project has been developed over the past two years into a collaborative effort to increase the immunization levels of Saint Paul Children.

Recently 50 volunteers from the various agencies, Saint Paul Public health, Children's Hospital of Saint Paul, a community clinic, pediatric clinics, the Minnesota Department of Health, WIC, and local Kiwanis group, provided outreach and information to approximately 3,000 shoppers at a TARGET store in one of Saint Paul's neighborhoods targeted for immunization improvements. This was a successful Sunday afternoon, and the results of contacts going to providers for immunization after the outreach and education was already realized within the first week after the event.

The Children's Immunization Project plans additional activities to increase the level of awareness to increase immunization rates among children.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Anne Kuettel, PHN from Saint Paul Public Health serves as Co-Chair of the Children's Immunization Project. This role has been vital to the growth and stability of the Project. The other Co-Chair is a representative from Children's Hospital of Saint Paul.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? The leadership has been enhanced on a personal and organizational level through this challenge, and recognition that Saint Paul Public Health is willing and able to take a leadership role and work collaboratively with many other agencies, to help achieve the overall goals.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Separating individual agency interests from the goals of the collaborative. How overcome? As with any collaborative effort with multiple agencies, this is a challenge.	Barrier 2: How overcome?

5. How is it funded? Private Sources, local agencies, Community Health Services Funding.

What is the approximate annual budget for this initiative?

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The overriding goals of the Project is to improve the immunization status of children, both as a collaborative, and within the individual organizations. The focus is on removing barriers and improving access, eliminating "missed opportunities", and providing education to clients and also to the provider community.

6b. Has this initiative been formally evaluated? No

7a. Do you think that this initiative would work if implemented in another urban community?

Why? This initiative could work anywhere that there is a commitment to partnerships as an effective means to address local public health issues.

7b. Has this program been replicated elsewhere?

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: HRS Pinellas County Public Health Unit
CITY/STATE: St. Petersburg, FL

CityMatCH CONTACT: Claude M. Dharamraj, MD
TELEPHONE: 813/824-6900

CONTACT FOR MORE INFORMATION: Susan Gilbert, Project Manager

1a. Initiative Name: Healthy Families Pinellas (HFP)

1b. Category(ies) that best applies to your initiative:
Prenatal Health - 06 Home visiting

2. Describe the initiative. Healthy Families Pinellas (HFP) is a family driven, community-based home visiting program administered by the HRS Pinellas County Public Health Unit (PinCPHU). The voluntary program works with the newborns of families targeted by census tracts through referrals from local hospitals. The key component strategy is the development of a family support plan(s) that seeks to empower the family as the ultimate broker of services. The intensity of service is based on the individual family level of need and is available for up to five years. Families are moved through various levels (i.e., Level I - Level IV) of service intensity according to established criteria. Paraprofessionals are used as home visitors, whose role is to help families reach their goals through completion and periodic assessment of a Family Support Plan (FSP). The paraprofessionals also work one-on-one with the family, teaching parenting skills, checking development of the infant, encouraging immunizations and well-baby visits and providing linkages to other community resources and services. Project services are available year round with 24-hr/day coverage utilizing an on-call system for evening, weekend, and holidays. The program is collaborative and the teams are made up of staff from PinCPHU, Family Service Centers, Inc., and the YWCA of Tampa Bay, Bayfront Medical Center and Morton Plant Hospital. There is an advisory committee to the project. Currently, there are three teams serving 17 census tracts in Pinellas County, with plans to expand each year for the next three years. The staff/families caseload ratio is 1/25.

3a. In planning and implementing this activity, what has been the leadership role of your health department? The HRS PinCPHU applied for and was awarded the grant for this collaborative in October 1992. The PinCPHU is the lead agency in the collaborative initiative and has responsibility for the entire budget.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? Healthy Families Pinellas has become a local model for case management initiatives. The program has helped to bring the Health Unit into the forefront as a serious player, in the child welfare, social service arena. Because of this, the link of medical services to social services has become much stronger in our community.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Lack of community resources like day care, housing, etc.

How overcome? Through informal, yet creative, collaborations, we have worked with the local housing authority and subsidized day care agency. This resulted in our clients being targeted for a special housing program and opened up 25 day care slots, we otherwise would not have had.

Barrier 2: Increasing number of illegal Hispanics, who are not eligible for community services such as day care.

How overcome? Not overcome; contact with the other programs experienced in dealing with such population. Also restructured program to meet needs of clients by translating existing materials into Spanish, hiring Spanish-speaking staff, and developing new materials.

5. How is it funded? Private source: Independent Taxing District for Children's Services.

What is the approximate annual budget for this initiative? 1994-95: $900,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The overall objective of the Healthy Families Pinellas Project is to prevent child abuse and neglect in the targeted families. Yes, the PinCPHU HFP Initiative have specific, measurable objectives. We have a data base and information is collected by forms and entered daily. We complete a semi-annual report to our funder (Juvenile Welfare Board of Pinellas County) and evaluator (University of South Florida).

There are different measurable objectives for successive years. 1) 75% of families referred by Bayfront Medical Center as high risk will accept home visiting services from HFP Family Support Worker (FSW). 2) 90% of families accepting home visiting services who remain active will have a documented individual FSP developed within the first 3 months. 3) 90% of active families with FSP will have been referred to community-based resources. 4) 85% of the families receiving home visiting services will not be involved in a confirmed report of child abuse and neglect. 5) 90% of families active in the program for 6 months or longer will be attentive to the medical needs of the infant. 6) 80% of families active in the program for 6 months or longer will show an improvement in bonding relationships. 7) 90% of all the enrolled infants will be assessed within the first 6th months of enrollment using the Denver II Development Assessment Tool. MINIMUM SERVICE LEVEL (1 Team) - 100 Families, 100 Children, 100 Adults

As of March 31, 1994 only 3% of families had any confirmed reports of abuse or neglect since enrollment, 100% target infants were up-to-date on well-baby visits and immunizations and 93% of mothers showed appropriate or improved bonding with their babies.

6b. Has this initiative been formally evaluated? Yes.

7a. Do you think that this initiative would work if implemented in another urban community? Yes, through Healthy Families America, it is being implemented in many urban communities throughout the United States.

Why? It works because it addresses challenges that all urban communities face.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? One in Florida: Polk County.

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: San Joaquin County Public Health Services
CITY/STATE: Stockton, CA

CityMatCH CONTACT: Susan DeMontigny, MSN, PHN
TELEPHONE: 209/468-0329

CONTACT FOR MORE INFORMATION:

1a. Initiative Name: Lead Poisoning Prevention Project Collaboration and Expansion

1b. Category(ies) that best applies to your initiative:
Child Health - 15 Lead poisoning

2. Describe the initiative. With the increasing effort to screen for and identify lead burdened children, San Joaquin County Public Health Services identified the need for a more comprehensive and collaborative effort between the various divisions involved with these children. The Maternal, Child, Adolescent Health (MCAH)/Lead Poisoning Prevention Program Coordinator organized the effort to develop a Multi-disciplinary Team (MDT) to meet monthly and develop policies and procedures to case manage children who are identified as lead burdened. The team consists of the Health Officer and representatives from Environmental Health, Public Health Nursing, Children's Medical Services, the Public Health Clinic, Health Education, and the Public Health laboratory. The team also reviews cases to determine if further efforts can or need to be made on behalf of these children. Various members of the MDT also provide community education, regarding lead poisoning and lead poisoning prevention, at community events or to community groups. When the opportunity developed, because of extra funding from the State, the Lead Program Coordinator, along with the MDT, was able to expand the existing project to include a community outreach pilot project. The pilot project has progressed well, already identifying and referring a number of children not previously screened. The next phase for the MDT will be to recruit community partners, to promote community awareness, and community support for this effort.

3a. In planning and implementing this activity, what has been the leadership role of your health department? Divisions within the Public Health Department (PHD) have been the primary participants, to date. Public Health Nursing has provided case management activities for individual families, and is now participating in the outreach project conducting a door-to-door campaign. Environmental Health provides source identification, and education regarding abatement, and methods to decrease exposure. They are also providing education at community events and to other interested groups. Children's Medical Services (CMS) provides education to providers regarding the necessity of screening children for lead according to the current CHDP guidelines, as well as Medical Case Management. The CMS Newsletter recently featured an article about lead poisoning and the lead poisoning prevention. The MCAH/Lead Poisoning Prevention Coordinator, in conjunction with the Health Officer, have begun a campaign to educate providers, and the general population, on the importance of screening for lead, providing education, and the follow-up activities provided by Public Health.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? As a result of the attempt to develop a collaborative effort, with those divisions of Public Health working with lead burdened children, the ability to provide services, including screening, assessment, education, case management and medical treatment and follow-up has increased significantly. The number of children identified as lead burdened has increased, as well as the quality of the follow-up care they receive, and services they are offered. Each Division is aware of their specific role in managing lead burdened children, and the concern over duplication of efforts is minimized.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Because of minimal funding, obtaining the manpower in the various Public Health Divisions to provide the additional time and service required by this project.

How overcome? Education to the managers of the various Divisions regarding the importance of identifying lead burdened children and the significant impact lead poisoning may have on their lives. Inviting the Division manager to participate on the MDT to develop policy and procedures, and the discussion of individual cases for case management.

Barrier 2: Mandated reporting, by laboratories, only at levels of 25ug/dl and above; cases of 10ug/dl to 24ug/dl were obtained haphazardly. Also, the lack of a denominator to determine a rate for San Joaquin County.

How overcome? The Public Health Laboratory and the Public Health clinics are currently submitting all lead levels to the Lead Poisoning Prevention Coordinator. A letter to other laboratories, that process lead levels for San Joaquin County, is being developed requesting their cooperation in providing the Health Department with a report of all their lead tests for children 18 years of age and under.

5. How is it funded? State Lead Poisoning Prevention Branch Allocation.

What is the approximate annual budget for this initiative? $130,000

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? Specific measurable objectives for the lead poisoning prevention program include case management until the individual has 2 lead levels 15 ug/dl or below or 1 level below 10 ug/dl. Prior to the development of the MDT, data was collected sporadically by the individual divisions. A monthly report is now developed that indicates the status of the case, and identifies new cases and case closures. Additional data is being generated for the pilot outreach project to examine the number of eligible children who have not been previously screened, and the number of newly screened children, identified by outreach, who have elevated lead levels.

6b. Has this initiative been formally evaluated? The MDT, and the pilot outreach project, have not been operational for a long enough period of time to formally evaluate, although the number of children identified as lead burdened has increased due to these efforts.

7a. Do you think that this initiative would work if implemented in another urban community? This initiative has the potential to be replicated in other similar size counties.

Why? The Health Department was able to attain the composition and involvement of representatives from the various divisions, in part due to the central location of the health department and the representatives involved, and the relatively small population size (500,000) and number of identified cases in the County. With increased case identification, the MDT approach may need to be modified.

7b. Has this program been replicated elsewhere? Unknown.

If yes, where?

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Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Tacoma-Pierce County Health
CITY/STATE:	Tacoma, WA
CityMatCH CONTACT:	Amedeo T. Tiam (designee)
TELEPHONE:	206/591-6537

CONTACT FOR MORE INFORMATION: JoDee Mosley (206/596-2842)

1a. **Initiative Name:** Readiness-To-Learn/Family Support Centers

1b. **Category(ies) that best applies to your initiative:**
Child Health - 17 School-linked/school-based services
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, Tb, HepB
Improving Access to Care - 25 Reducing transportation barriers, 26 Expanding private sector linkages, 29 Schools and health connections
Strengthening Urban Public Health Systems - 41 Building coalitions and partnerships

2. **Describe the initiative.** The Readiness-to-Learn/Family Support Center project brings together a multidisciplinary team of service providers from public and private agencies and community leaders and volunteers to deal with barriers that affect children's performance in school.

It is the goal of the Tacoma-Pierce County Health Department (TPCHD) to assist in initiating, stabilizing and filling in service gaps where needed, initially, and to assist the different communities and neighborhoods, if appropriate, acquire ownership of the program so that it eventually turns into a truly community-based and community-directed program. Consistent with this goal is the TPCHD's support for the development of Community Advisory Committees whose main role will be to advise the program staff in matters pertaining to program and service delivery.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Family Support Center/Readiness-To-Learn program is a broad and encompassing program which allows the TPCHD to provide preventive programs so that its involvement in intervention services--services that must be provided when a health crisis of some kind occurs - can start to diminish. Needless to say, behaviors and environments that translate into health risk factors have a better chance of being addressed adequately and resolved in a prevention mode.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The organizations the TPCHD is partnering with are all community based. This fact provides a unique opportunity for the TPCHD to bring its services to the communities where services are needed.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Turf & Bureaucracy/Who's in control.

How overcome? Continue working together with outside and community based agencies; right people are together at the discussion table; highest access to policy makers.

Barrier 2: Community Involvement/Not in My Backyard!

How overcome? Work with Community-Based Groups; community/neighborhood leaders are invited and participate in the planning and implementation; Set limits.

5. How is it funded? City/County/Local government funds; and General state funds.

What is the approximate annual budget for this initiative? $990,355.00

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? This is a new project in which our Office of Community Assessment is currently in the process of refining an evaluation measurement.

6b. Has this initiative been formally evaluated? N/A

7a. Do you think that this initiative would work if implemented in another urban community? Yes

Why? It is expected that assisting children and their families meet basic needs and resolve conflicts will contribute to children's readiness for learning and minimize risky behaviors that leads to serious health problems.

7b. Has this program been replicated elsewhere? No

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: Pima County Health Department
CITY/STATE: Tucson, AZ

CityMatCH CONTACT: Janice Nusbaum
TELEPHONE: 602/740-8611

CONTACT FOR MORE INFORMATION: Barbara L. Maack (602/298-3888)

1a. **Initiative Name:** District Office TB Prevention Therapy and Follow-Up

1b. **Category(ies) that best applies to your initiative:**
Other Outreach - 22 Communicable diseases: STD, HIV/AIDS, TB, HepB

2. **Describe the initiative.** As a consequence of staff turnover at the core TB program it was determined that the job of monitoring compliance with medication prophylaxis would not get done. It was felt that by involving PHNs at the District Offices this step would increase the availability of staff for service delivery. Also, by making the location of service delivery more accessible and convenient for the client, that it might increase compliance with medication prophylaxis. The three areas where District Office PHN staff are involved to assist the central TB program are: 1) Surveillance of individuals and families on prophylactic INH medication. Staff monitors refill dates and will contact client if client does not initiate call when medications are due. A PHN interviews the client and completes a flow sheet before issuing refills. This information helps to identify any side effects and to assess compliance with taking the medication. 32% of the new TB records opened this past year were children. 21% were between the ages of 5 and 19 years and 11% were less than 5 years of age. In addition, 45% were women in the child bearing years of 20 to 49 years. 2) Skin testing in District Offices/Clinics. During the past year 63% of non-high risk PPDs were done at the District Offices/Clinics. Of those with known results, 6% were positive. Nationally the rate is 4%. Our higher statistic can be explained by our proximity to Mexico, where the incidence of TB is higher than that in the U.S.A. 3) Referrals from three local hospitals and one clinic for follow-up of pregnant women with positive PPDs. Family contacts were skin tested and mothers were placed on prophylaxis after the birth of the baby. Almost all of the women were of Hispanic ethnicity. 64 referrals were received for follow-up.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** This initiative was planned and implemented entirely by the Public Health Nursing Division. This was not a collaborative effort with other entities. It was a change in service delivery method rather than the establishment of a new program.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** N/A.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Core TB program staff turnover.

How overcome? 1) Education of new staff and follow-up, supervision and support of staff activities by Nurse Managers at the District Offices and the TB program. 2) Integration of services made possible by an organizational structure that allows for a decentralized and generalized PHN program.

Barrier 2: Problems associated with decentralization of service delivery.

How overcome? 1) Constant communication between the core TB program and the staff at the district offices. 2) A matrix form of management was designed and implemented by the Division of Public Health Nursing, which facilitated communication.

5. How is it funded? City/County/Local government funds; CDC Communicable Disease Dollars (through Arizona Department of Health Services).

What is the approximate annual budget for this initiative? This initiative and TB program are integrated into the overall Public Health Nursing Division budget.

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? The core TB program objective was to increase completion rate of those placed on prophylaxis from 79% to 85%. For this past FT 93-94 the District Offices achieved an 90% completion rate for those eligible to complete therapy. The change in percent of completion rate increased 31% from that of the 61% of the centralized office. This data was collected using the "TB Data and Monitored Base Program."

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes.

Why? If: a) the local health department has District Public Health Nursing Services; b) and if their organizational structure allowed for a generalized Public Health Nursing program rather than categorical, with decentralization of services.

7b. Has this program been replicated elsewhere? No.

If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT: District of Columbia Department of Human Services
CITY/STATE: Washington, D.C.

CityMatCH CONTACT: Patricia A. Tompkins
TELEPHONE: 202/727-0393

CONTACT FOR MORE INFORMATION:

1a. **Initiative Name:** OMCH Cross Training Efforts

1b. **Category(ies) that best applies to your initiative:**
Improving Access to Care - 33 Increasing social support systems; 35 Increasing access to Medicaid
Strengthening Urban Public Health Systems - 36 Staff training

2. **Describe the initiative.** OMCH coordinated the drafting and subsequent signing in 1991 of a cooperative agreement among Title XIX Medicaid Programs, Title V Maternal and Child Health Programs, WIC/Commodity Supplemental Food Programs, and the Income Maintenance Administration. Cross training between MCH services and Medicaid began in 1993. The first training session focused on MCH services including primary care, such as the neighborhood health centers and the Health Center for Children with Special Needs, as well as the Healthy Start Project, the Pregnancy Risk Assessment Monitoring System, Pregnancy Nutrition Surveillance System, Pediatric AIDS, and Synergy. The cross training that was adopted by the participants (4 sessions) will be completed in September, 1994. The training components consists of: MCH Title V and MCH Programs, Medicaid/Income Maintenance Administration Managed Care, WIC/CSFP, and alternative programs/projects.

Most recently, OMCH approached two units within the Commission on Social Services; namely the Office of Paternity and Child Support Enforcement (OPCSE) and Family and Child Services Division (FCSD). A formal agreement has been signed with the OPCSE to promote public awareness, integrate activities and improve coordination of services and resources by both the OMCH and OPCSE. The FCSD collaboration came about in view of the increased number of child abuse and neglect cases being seen in the D.C. Court system. OMCH felt a need to form a partnership to assist in alleviating some of the problems caused by and associated with, child abuse and neglect. It was determined that the emphasis should be placed on cross training of all DHS staff who have contact with families.

3a. **In planning and implementing this activity, what has been the leadership role of your health department?** The Commission of Public Health has assumed the leadership role in this activity by contacting other DHS Commissions, Divisions, etc. to participate in this cross training activity. Contacts have also been made with private sector community-based organizations.

3b. **Has the leadership of the health department been enhanced as a result of this activity? If so, why?** The leadership has been enhanced in that we are seen as the initiator in this strategy and thus viewed as having insight and the ability to respond to problems rather than react to problems.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Maintaining the cooperation of the collaborators. How overcome? This issue will probably be a constant one which we will continue to attempt to alleviate.	Barrier 2: How overcome?

5. **How is it funded?** City/County/Local government funds; MCH block grant funds; Other Federal funds.

   What is the approximate annual budget for this initiative? Basically in-kind services/staff manpower.

6a. **Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date?** Yes. We can measure the number of persons attending, participant satisfaction, and pre-testing and post-testing on knowledge of the programs. Our major accomplishments were in getting three signed, formal agreements with Medicaid, et al. as mentioned previously, the Office of Pre-School and Day Care of the United Planning Organization, and with the Office of Paternity and Child Support Enforcement.

6b. **Has this initiative been formally evaluated?** No. An evaluation is scheduled for October 1, 1994.

7a. **Do you think that this initiative would work if implemented in another urban community?** Yes.

   Why? It requires someone to take the initiative and make contact with organizations that provide similar services and determine how they can assist one another.

7b. **Has this program been replicated elsewhere?** Don't know.

   If yes, where?

1994 Urban MCH Leadership Conference Profile

Describe your health department's most successful recent initiative in the area of maternal and child health.

HEALTH DEPARTMENT:	Division of Public Health
CITY/STATE:	Wilmington, DE
CityMatCH CONTACT:	Anita Muir
TELEPHONE:	302/995-8632

CONTACT FOR MORE INFORMATION: Kris Bennett

1a. Initiative Name: Enhanced Care for Kids - Pilot Project

1b. Category(ies) that best applies to your initiative:
Women's Health - 02 Family planning, 03 Breast/cervical cancer
Prenatal Health - 04 Prenatal care; 06 Home visiting

2. Describe the initiative. Two years ago, the Nemours Foundation began an initiative to establish Children's Clinics to serve low income and Medicaid children across the State of Delaware through a managed care waiver. At the outset, it was clear that these pediatric practices would be of great benefit to a population without a medical home/access to evening and weekend care, but that a great deal of education and follow-up would be needed to ensure access and utilization of a traditional medical system.

Public Health established a collaborative relationship with the Director of the Children's Clinics and proposed a model for Enhanced Care for Kids similar to those established for pregnant women throughout the states. The role of the Public Health nurse would be to link children with their medical home, and to other social services including Medicaid. They would visit families at home to enhance the education received in clinics and promote good utilization of the medical system.

Regular collaborative meetings were established, which included Medicaid to develop and pilot the model, and to address needs and problems as they arose.

Currently, there are five (5) clinics in operation in the Wilmington area and each is assigned a liaison nurse to work with them to receive and make referrals. They attend regular case management meetings and also serve on the community advisory councils for each site.

3a. In planning and implementing this activity, what has been the leadership role of your health department? When the initiative for Children's Clinics was planned, Public Health was not at the table. However, their first site was not ready and Public Health was asked to share clinic space temporarily with Nemours. This was the door opener to establish a day-to-day working relationship and a chance to teach them what Public Health was about. It was an opportunity to establish the collaborative meetings and begin laying the ground work.

3b. Has the leadership of the health department been enhanced as a result of this activity? If so, why? It is an important lesson to recognize the value of giving up some territory in order to gain an important private-public collaborative relationship. It takes time and effort to maintain this relationship.

4. What have been the greatest barriers faced in implementing this initiative?

Barrier 1: Each site operates within a degree of independence - each physician sets up a practice to their style. Therefore, not all are as willing to make referrals and work with Public Health nurses.

How overcome? The collaborative meetings held by DPH leadership and Nemours Director served as the place to address barriers and overcome problems. In one particular situation, a change in nurse assigned helped. In another, having the public health nurse link with a nurse practitioner at the site improved the linkage.

Establishing regularly scheduled meetings at each site where referrals were made also helped.

Barrier 2: Many people (clients and community) expected this clinic system to operate just like Public Health Clinics had operated - rather than like private pediatric practices.

How overcome? Several meetings within state agencies and within Public Health were held to answer questions with regard to the Children's Clinic and how to receive services. Question and answer sheets were developed and distributed to address the "most asked" questions.

5. How is it funded? General state funds. MCH block grant funds. We would like to pursue Medicaid reimbursement as a wrap-around service or as an integral part of future managed care.

What is the approximate annual budget for this initiative? $35-40,000 (5 nurses x .2 FTE)

6a. Does this MCH initiative have specific, measurable objectives? How is data collected and used in monitoring the initiative? What have been its major accomplishments to date? We have examined the number and types of referrals, the outcomes of cases and the general satisfaction of the clinics with the liaison pilot project. A more formal evaluation is planned.

6b. Has this initiative been formally evaluated? No.

7a. Do you think that this initiative would work if implemented in another urban community? Yes, this is classic Public Health at work.

Why? The key is establishing an understanding by the community of what Public Health is uniquely qualified to provide. This requires leadership at many different levels to communicate a consistent message.

7b. Has this program been replicated elsewhere? Yes.

If yes, where? Virginia (CHIP)

APPENDIX A: 1994 Conference Planning Committee

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APPENDIX B: 1994 Conference Program

"Effective Leadership During Times of Transition"

1994 Urban Maternal and Child Health Leadership Conference

Saturday, September 17, 1994

12:00pm - 5:00pm	**Conference Registration**	**Phillips Ballroom Foyer**
2:00pm - 5:30pm	Optional Preconference Workshops (pre-registration is required)	
	• **Data 101: Qualitative Problem Solving in Urban MCH**	**National Gallery Ballroom A**

Gilberto Chavez, MD, MPH
Chief, MCH Epidemiology Section
California Department of Health
Sacramento, CA

Ed Ehlinger, MD, MPH
Director, Division of Personal Health Services
Minneapolis Department of Health & Family Support
Minneapolis, MN

Cara Krulewitch, MD, MPH
Epidemiologist, Office of Maternal & Child Health
D.C. Department of Human Services
Commission of Public Health
Washington, DC

Beth Macke, MA, PhD
EIS Officer
Division of Reproductive Health
Pregnancy and Infant Health Branch
Centers for Disease Control & Prevention
Atlanta, GA

Magda G. Peck, ScD, PA
CityMatCH Executive Director/CEO
Chief, Section on Child Health Policy
University of Nebraska Medical Center
Omaha, NE

Ken Schoendorf, MD, MPH
Division of Analysis, Epidemiology & Health Promotion
Infant & Child Health Studies Branch
National Center for Health Statistics
DHHS/Public Health Services/CDC
Hyattsville, MD

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Saturday, September 17, 1994

- **Program Evaluation: How Do You Know You've Done What You Wanted?** **Renwick Suite**

Peter Morris, MD, MPH
Deputy Health Director for MCH
Wake County Department of Health
Raleigh, NC

Mary Peoples-Sheps, DrPH
Associate Professor, Public Health Nursing
University of North Carolina School of Public Health
Chapel Hill, NC

Lou Kelley Brewer
Assistant Health Director
Wake County Department of Health
Raleigh, NC

6:30pm - 8:30pm **CityMatCH Board of Directors Meeting** **Freer Suite**

Sunday, September 18, 1994

8:30am - 11:30am **Optional Preconference Workshops** (continued)
(pre-registration is required)

- **Data 102: Advanced Data - Needs Assessment** — **Renwick Suite & Freer Suite**

Gilberto Chavez, MD, MPH
Chief, MCH Epidemiology Section
California Department of Health
Sacramento, CA

Ed Ehlinger, MD, MPH
Director, Division of Personal Health Services
Minneapolis Department of Health & Family Support
Minneapolis, MN

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Epidemiologist, Office of Maternal & Child Health
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Division of Analysis, Epidemiology & Health Promotion
infant & Child Health Studies Branch
National Center for Health Statistics
DHHS/Public Health Services/CDC
Hyattsville, MD

11:00am - 6:30pm **Conference Registration** — **Phillips Ballroom Foyer**

12:00pm **Conference Kickoff Luncheon** — **National Gallery Ballroom**

Sunday, September 18, 1994

12:30pm - 12:45pm	**Welcoming Remarks:**	**National Gallery Ballroom**

Len Foster, MPA
Co-Chair, 1994 Urban MCH Leadership Conference
Deputy Director of Public Health
Orange County Health Care Agency
Santa Ana, CA

Marlene N. Kelley, MD
Acting Commissioner
D.C. Commission of Public Health
Washington, D.C.

Audrey Hart Nora, MD
Director, Maternal and Child Health Bureau
Assistant Surgeon General
U.S. Public Health Service
Rockville, MD

Ciro Sumaya, MD, MPH, TM
Administrator, Health Resources and Services Administration
Department of Health and Human Services
Rockville, MD

1:00pm - 1:45pm	**Kickoff Keynote Address:**	**Phillips Ballroom**

Ciro Sumaya, MD
Administrator, Health Resources and Services Administration
Department of Health and Human Services
Rockville, MD

Keynote Speaker:

Joycelyn Elders, MD
Surgeon General
U.S. Public Health Service
U.S. Department of Health and Human Services
Washington, D.C.

1:45pm - 2:00pm **Break**

Sunday, September 18, 1994

2:00pm -	4:00pm	Panel 1: **Collaborative Models of MCH Leadership in Public Health Problem Solving: Healthy Start Projects** Moderator: **Shirley Fleming, DrPH, RN, CNM** Deputy Health Commissioner Chicago Department of Health Chicago, IL **Maribeth Badura** Deputy Branch Chief, Program Operations Division of Healthy Start Maternal and Child Health Bureau Rockville, MD **Sheila Webb, RN, MS** Deputy Director of Health City of New Orleans Health Department New Orleans, LA **Karen K. Butler, MPH** Commissioner of Health Cleveland Department of Public Health Cleveland, OH	**Phillips Ballroom**
4:00pm -	4:15pm	**Break**	**Freer Suite**
4:15pm -	4:45pm	**CityMatCH Orientation for New Members** (optional)	**Phillips Ballroom**
4:45pm -	6:15pm	**CityMatCH Annual Business Meeting** (open to all)	**Phillips Ballroom**
6:30pm -	8:00pm	**Co-Sponsors Networking Reception** Funded by the National March of Dimes Birth Defects Foundation	**National Gallery Ballroom**

Monday, September 19, 1994

7:00am - 8:00am **Continental Breakfast** **Freer Suite**

8:00am - 9:00am **"Urban Children in Need: Responsive and Responsible Leadership"** **Phillips Ballroom**

Moderator: **Magda G. Peck, ScD, PA**
CityMatCH Executive Director/CEO
Chief, Section on Child Health Policy
University of Nebraska Medical Center
Omaha, Ne

David Hamburg, MD
President
Carnegie Corporation of New York
New York, NY

Margaret A. Hamburg, MD
Commissioner of Health
New York City Department of Health
New York, NY

9:00am - 10:15am Panel 2: **National, Federal, State, and Local Approaches to Implementing the Childhood Immunization Initiative** **Phillips Ballroom**

Moderator: **Len Foster, MPA**
Deputy Director of Public Health
Orange County Health Care Agency
Santa Ana, CA

Mrs. Betty Bumpers
Former First Lady of the State of Arkansas
Every Child by Two
The Carter/Bumpers Campaign for Early Immunization
Washington, DC

Walter A. Orenstein, MD
Director, National Immunization Program
Centers for Disease Control & Prevention
Atlanta, GA

Donald Williamson, MD
State Health Officer
Alabama State Department of Health
Montgomery, AL

C.M.G. Buttery, MD
Director, Department of Public Health
Virginia State Health Department - City of Richmond
Richmond, VA

10:15am - 10:30am **Break** **Freer Suite**

10:30am - 12:00pm Small Groups I:
The Essentials of Urban MCH Leadership (See Profiles, Question 3)

Group 1:	**Ambassador Suite 1**
Group 2:	**Ambassador Suite 2**
Group 3:	**Hirschorn Suite**
Group 4:	**Renwick Suite**
Group 5:	**Corcoran Suite**
Group 6:	**Smithsonian Suite**

Monday, September 19, 1994

12:00pm -	1:30pm	**CityMatCH Regional Planning Luncheon**	**National Gallery Ballroom**
1:30pm -	2:00pm	**Break**	
2:00pm -	3:45pm	**Concurrent Topical Workshops**	

1. School-Based Clinics and Local Health Departments — **Hirschorn Suite**

Moderator:	**Paul Melinkovich, MD** Associate Health Director, Community Health Services Denver Department of Health & Hospitals Denver, CO
School Based Clinics - National Overview	**Julia Graham Lear, PhD** Director, Making the Grade The George Washington University Washington, DC
School Based Clinics and Health Care Reform	**Deborah von Zinkernagel** Staff Member U.S. Senate Committee on Labor & Human Resources Washington, DC
The Portland Experience	**Mary L. Hennrich, RN, MS** Health Plan Administrator, CareOregon Multnomah County Health Department Portland, Oregon
The Denver Experience	**Paul Melinkovich, MD** Associate Health Director, Community Health Services Denver Department of Health & Hospitals Denver, CO

2. Assessment, Policy Development and Assurance in Action: Community Infant/Child Death Review Programs — **Renwick Suite**

Moderator:	**Elizabeth Zelazek, RN, MS** Public Health Nursing Manager City of Milwaukee Health Department Milwaukee, WI
What Will Work: Milwaukee's Infant Mortality Review Project	**Elizabeth Zelazek, RN, MS** Public Health Nursing Manager City of Milwaukee Health Department Milwaukee, WI
What is Working: The New York Experience	**Karin Duncan, MSN** Director, Maternal-Child Health Monroe County Department of Health Rochester, NY
What Has Worked: Boston's Case by Case Infant Mortality Review Project	**Karen Power, MPH** Director, Office of Research & Health Statistics Boston Department of Health & Hospitals Boston, MA

3. TB Reemerges in Urban Communites: Implications for MCH **Corcoran Suite**

Moderator:	**Gary Butts, MD** Deputy Commissioner New York City Department of Health New York, NY
The Case of Orange County	**Hugh F. Stallworth, MD** Health Officer & Director of Public Health Orange County Health Care Agency Santa Ana, CA
The Case of Garland	**Grace Rutherford, MSN** Medical Coordinator City of Garland Health Department Garland, TX
The Case of New York City	**Gary Butts, MD** Deputy Commissioner New York City Department of Health New York, NY

4. Women's Health 1994: Three Health Issues of Concern to Women **Smithsonian Suite**

Moderator:	**Brenda Coulehan, RN, MA** Family Health Services Coordinator Memphis & Shelby County Health Department Memphis, TN
Women's Health: Folic Acid Supplementation	**Lisa Sanford, RN, MPH** Chief, Preventive Health Services City of Laredo Health Department Laredo, TX
Women's Health: Colposcopy Services	**Margaret Gier, RNC, MS** Manager, Women's Health Programs Tri-State Health Department Aurora, CO
Women's Health: Mammography	**Jillian Jacobellis, CNM, MS** Former Director of Policy, Planning & Program Development Salt Lake City/County Health Department Salt Lake City, UT

3:45pm -	4:00pm	**Refreshment Break**	
4:00pm -	5:45pm	**Repeat of Concurrent Topical Workshops**	
		1. School-Based Clinics and Local Health Departments	**Hirschorn Suite**
		2. Assessment, Policy Development and Assessment in Action: Community infant/Child Death Review Programs	**Renwick Suite**
		3. TB Reemerges in Urban Communites: Implications for MCH	**Corcoran Suite**
		4. Women's Health 1994: Three Health Issues of Concern to Women	**Smithsonian Suite**
5:45pm		**Adjourn for the day**	

Tuesday, September 20, 1994

7:30am - 8:30am **Continental Breakfast** **Freer Suite**

8:30am - 10:00am **Violence and Public Health: Problems to Policies** **Phillips Ballroom**

Moderator: **Ed Ehlinger, MD, MPH**
Director, Division of Personal Health Services
Minneapolis Department of Health & Family Support
Minneapolis, MN

The Honorable Ellen Anderson
Minnesota State Senator
DFL-St. Paul
Minnesota Legislative Commission on
Children, Youth & Family
St. Paul, MN

Mike Christenson
Executive Director
Medica Foundation
Minneapolis, MN

Yusef Mgeni
Executive Director
Urban Coalition
St. Paul, MN

10:00am - 10:30am **Break**

10:30am - 12:00pm **Small Group II:**
What Works: Local Public Health Departments' Response to Violence
Group 1: **Renwick Suite**
Group 2: **Corcoran Suite**
Group 3: **Smithsonian Suite**
Group 4: **Hirschorn Suite**
Group 5: **National Gallery Ballroom A**
Group 6: **National Gallery Ballroom B**

12:00pm - 4:00pm **Open Time:**
Lunch on Your Own
Capitol Hill Visits (on your own)

1:00pm - 4:00pm Set Up Displays for Exhibitors Showcase **National Gallery Ballroom**

12:30pm - 3:45pm **Field Visits to D.C. Area MCH Programs** (pre-registration required)
Meet in hotel lobby promptly at 12:25pm.

Tuesday, September 20, 1994

4:00pm - 5:30pm	Panel 4: **Health Care Reform Update: National and State Perspectives** **National Speaker:** **Catherine Hess, MSW** Executive Director Association of Maternal and Child Health Programs Washington, DC **State Speaker:** **Maxine D. Hayes, MD, MPH** Assistant Secretary DOH/Community & Family Health Department of Social & Health Services Olympia, WA	**Phillips Ballroom**
5:30pm - 6:00pm	**Break**	
6:00pm - 8:00pm	CityMatCH **Networking Reception & Exhibitors Showcase**	**National Gallery Ballroom**
6:30pm - 7:30pm	**SpotLights Presentations**	**National Gallery Ballroom**

Wednesday, September 21, 1994

8:00am - 8:45am **CityMatCH Regional Planning Breakfast** — **National Gallery Ballroom**

9:00am - 10:45am Panel 5: **Local Public Health Leadership in Times of Transition** — **Phillips Ballroom**

Moderator: **Donalda Dodson, RN, MPH**
Public Health Manager
Marion County Health Department
Salem, OR

Gary Oxman, MD, MPH
Health Officer
Multnomah County Health Department
Portland, OR

Meredith Tipton, RN, MPH
Director
City of Portland Public Health Division
Portland, ME

Martin Wasserman, MD, JD
Health Officer
Prince George's County Health Department
Cheverly, MD

10:45am - 11:00am **Break**

11:00am - 12:00pm **Summing Up: Next Steps for Urban MCH Leaders and CityMatCH** — **Phillips Ballroom**

Len Foster, MPA
Co-Chair, 1994 Urban MCH Leadership Conference
Deputy Director of Public Health
Orange County Health Care Agency
Santa Ana, CA

Magda G. Peck, ScD, PA
Co-Chair, 1994 Urban MCH Leadership Conference
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Omaha, NE

Carolyn Slack, MS, RN
Immediate Past-Chairperson, CityMatCH Board of Directors
Administrator, Family Health Services
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Columbus, OH

12:00pm **Final Adjournment**

12:30pm - 2:00pm **1994-95 CityMatCH Executive Committee to the Board of Directors Luncheon**

APPENDIX C: 1994 CONFERENCE PARTICIPANTS

Participating Urban MCH Leaders

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